Public Document Pack

Health & Wellbeing Board

To:
Councillor Yvette Hopley (Chair)
Councillor Margaret Bird (Vice-Chair)
Councillor Tamar Barrett
Councillor Janet Campbell
Councillor Humayun Kabir
Councillor Joseph Lee
Annette McPartland, Corporate Director Adult Social Care & Health (DASS)
Rachel Flowers, Director of Public Health - Non-voting
Edwina Morris, Healthwatch
Jon Northfield, South London and Maudsley NHS Foundation Trust
Yemisi Gibbons, Croydon Health Services NHS Trust - Non-voting
Steve Phaure, Croydon Voluntary Action - Non Voting
Matthew Kershaw, NHS Croydon Clinical Commissioning Group (CCG)
Debbie Jones, Corporate Director for Children, Young People and Education

A meeting of the **Health & Wellbeing Board** will be held on **Wednesday, 24 January 2024** at **2.00 pm** in **Council Chamber, Town Hall, Katharine Street, Croydon CR0 1NX**

Katherine Kerswell
Chief Executive
London Borough of Croydon
Bernard Weatherill House
8 Mint Walk, Croydon CR0 1EA

Michelle Ossei-Gerning
michelle.gerning@croydon.gov.uk
www.croydon.gov.uk/meetings
16 January 2024

The agenda papers for all Council meetings are available on the Council website www.croydon.gov.uk/meetings

If you require any assistance, please contact Michelle Ossei-Gerning as detailed above.

AGENDA – PART A

1. Apologies for Absence

To receive any apologies for absence from any members of the Committee.

2. Minutes of the Previous Meeting (Pages 5 - 8)

To approve the minutes of the meeting held on Wednesday 18 October 2023 as an accurate record.

3. Disclosure of Interests

Members are invited to declare any disclosable pecuniary interests (DPIs) and other registrable and non-registrable interests they may have in relation to any items(s) of business on today's agenda.

4. Urgent Business (if any)

To receive notice of any business not on the agenda which in the opinion of the Chair, by reason of special circumstances, be considered as a matter of urgency.

5. Public Questions

Public Questions should be submitted before 12 noon on Friday 19 January 2024 to democratic.services@croydon.gov.uk. Any questions should relate to items listed on the agenda. 15 minutes will be allocated at the meeting for all Public Questions that are being considered.

6. Winter Pressures

A verbal update on the Winter Pressures.

7. Better Care Fund 2023/24 Quarter 2 Report (Pages 9 - 26)

The Better Care Fund Quarter 2 Submission for 23-24 for Croydon to NHS England is attached.

8. Frontrunner programme update (Pages 27 - 78)

This report provides an update on the timeline, progress, risk and issues with the Frontrunner programme.

9. South West London/ICS/ICB Restructure Update

A verbal update on the restructure of the SWL, ICS and ICB.

10. Joint Local Health and Wellbeing Strategy (JLHWS): Healthwatch Croydon Community Engagement Session - Summary Report (Pages 79 - 104)

A summary report of the Joint Local Health and Wellbeing Strategy - Healthwatch Croydon Community Engagement Session is attached.

11. Croydon Joint Local Health and Wellbeing Strategy Refresh: progress update and next steps (Pages 105 - 186)

This report provides updates to the refresh, summarising insights from the joint Health and Wellbeing Board and Health and Care Board workshop.

12. Exclusion of the Press and Public

The following motion is to be moved and seconded where it is proposed to exclude the press and public from the remainder of a meeting:

"That, under Section 100A(4) of the Local Government Act, 1972, the press and public be excluded from the meeting for the following items of business on the grounds that it involves the likely disclosure of exempt information falling within those paragraphs indicated in Part 1 of Schedule 12A of the Local Government Act 1972, as amended."

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Health & Wellbeing Board

Meeting of held on Wednesday, 18 October 2023 at 2.00 pm in Council Chamber, Town Hall, Katharine Street, Croydon CR0 1NX

MINUTES

Present: Councillor Yvette Hopley (Chair);
Councillor Margaret Bird (Vice-Chair);
Councillor Tamar Barrett
Councillor Janet Campbell
Councillor Joseph Lee

Also Present:

Apologies: Councillor Humayun Kabir

PART A

56/23 **Minutes of the Previous Meeting**

The Chair requested that the spelling of Matthew Kershaw's name be corrected in the minutes of the meeting held on 21 March 2023.

RESOLVED that the minutes of the meetings of 21 March 2023 and 28 June 2023 be approved as an accurate record of proceedings with the above edition.

57/23 **Disclosure of Interests**

There were no disclosures at this meeting.

58/23 **Urgent Business (if any)**

The Chair mentioned that the Health and Wellbeing Board chairs had met to discuss shared children's cancer services and that South West London Scrutiny would be reviewing the arrangements.

The Chair sought agreement from the Board that it makes a recommendation to the joint Scrutiny committee to review the proposals locally, to which members agreed.

59/23 **Public Questions**

There were no public questions at this meeting.

60/23 **Better Care Fund 2023-25 - Letter from NHS England**

It was explained that this letter had been included in the agenda as an update to the Health and Wellbeing Board that the Better Care Fund had been approved nationally.

In response to questions from members officers clarified that the funding was subject to a Section 75 agreement with timescales set by NHS England, and that the council was on track to meet its obligations in relation to that agreement.

RESOLVED:

To note the letter received from NHS England.

61/23 **Update on South West London ICS Strategy**

The next two agenda items were taken together.

In response to members' concerns, it was clarified that one of the six strategic priorities listed was to target mental health and early access to resources and early identification of mental health vulnerability.

Officers also explained that they would bring an update report to the Health and Wellbeing Board in the future to provide assurance around the success of the strategy.

The Chair requested that the report should be presented to the Board within the next year.

RESOLVED:

2.1 To note the publication of the Integrated Care Partnership Strategy for South West London and the process for agreeing the Croydon place response to the draft.

2.2 To note the publication of the NHS Joint Forward Plan for SWL including the Croydon Health and Wellbeing Strategy priorities reflected.

2.3 To note the launch of the SWL Investment funding and the commitment for Croydon system partners to work collaboratively to identify and progress applications to address key priorities for Croydon Place.

62/23 **NHS Joint Forward Plan**

63/23 **South West London Mental Health Strategic Plan**

In response to members' questions, officers explained that a key part of the plan was around the mental health and emergency departments' crisis pathway. It was explained that there was a huge demand for inpatient beds, and that there was a knock-on effect for housing, all of which was provided for within the plan.

Officers also explained that timely access to the correct care and prevention work was a key part of the plan, with a focus on removing pressure of mental health primary care from GP surgeries. This could be achieved, for example, by targeting support for young people.

The Chair requested that an update be brought back to the Board which included information on support for young people suffering from mental ill health as a consequence of domestic violence.

RESOLVED:

- to note the SWL ICS Mental Health Strategy has been developed and is providing the future direction for MH transformational work across the six boroughs.

64/23 **Croydon Dementia Strategic Plan**

65/23 **Croydon Mental Health Summit Update**

RESOLVED:

- to support the Council to the strategic and operational integration partnership arrangements required to successfully deliver the plan and relevant actions.

66/23 **Croydon Joint Local Health and Wellbeing Strategy Refresh: October Update**

RESOLVED:

2.1 To note progress to date.

2.2 To agree on the next steps regarding strategy development.

2.3 To confirm attendance at the partnership planning workshop organised for Thursday, 9 November 2023, 10:00-13:00.

67/23 **CUH Update on improvement plan following CQC rating**

In response to members' questions officers clarified that there had been quite a lot of staffing changes since a hiatus during the years covering the Covid-19 pandemic, which could add some challenge largely in due to the loss of corporate memory; but that officers saw this as an opportunity to refresh and reenergise teams and did not think it had an overall negative effect on the trust.

A national staff survey was currently underway to ensure that the right health and wellbeing support was in place for staff to try to improve the staff experience on the whole.

It was also confirmed that a new NHS health centre was planned to open in Coulsdon.

68/23 **Exclusion of the Press and Public**

It was not necessary to exclude the press and public from any portion of this meeting.

The meeting ended at 3.37 pm

Signed: .....

Date: .....

LONDON BOROUGH OF CROYDON

REPORT:		**HEALTH AND WELLBEING BOARD**
DATE OF DECISION		**WEDNESDAY 24TH JANUARY 2024**
REPORT TITLE:		**BETTER CARE FUND 2023 /24 QUARTER 2 REPORT**
CORPORATE DIRECTOR / DIRECTOR:		**Annette McPartland** **Corporate Director** **Adult Social Care & Health Directorate** **Matthew Kershaw** **Chief Executive / Place Based Lead for Health** **Croydon Health Services NHS Trust**
LEAD OFFICER:		**Daniele Serdoz, Deputy Director for Primary and Community care, SWL ICB (Croydon)** **Email: daniele.serdoz@swlondon.nhs.uk** **Telephone: 020 3923 9524**
KEY DECISION? [Insert Ref. Number if a Key Decision] ***Guidance**: A Key Decision reference number will be allocated upon submission of a forward plan entry to Democratic Services.*	**NO**	REASON: The Better Care Fund (BCF) is an annual grant and is one of the Government's national vehicles for driving health and social care integration. It requires the South West London Integrated Care Board (ICB) and Croydon Council to agree a joint plan on how the grant will be used, aligned to the BCF Policy Framework. The plan enables use of pooled budgets to support integration, governed by an agreement under section 75 of the NHS Act (2006)
CONTAINS EXEMPT INFORMATION? ***(* See guidance)***	**NO**	Public

1. SUMMARY OF REPORT

1.1 To ensure that both national and local governance is completed correctly, the Health and Wellbeing Board is asked to sign off the Better Care Fund Quarter 2 Submission for 23-24 for Croydon to NHS England

2. RECOMMENDATIONS

2.1 For the reasons set out in the report and its appendices, the Health and Wellbeing Board is recommended to sign off the BCF Quarterly submission for 2023/24 to NHS England.

3. REASONS FOR RECOMMENDATIONS

3.1 Signing off the submission of the end of year report to NHS England sits within the legislative remit of the Health and Wellbeing Board. See section 5 of this report.

4. BACKGROUND AND DETAILS

4.1 The Better Care Fund (BCF) is one of the Government's national vehicles for driving health and social care integration. It requires Place Based NHS ICB's and local government to agree a joint plan, owned by the Health and Wellbeing Board (HWB). These plans enable using pooled funds to support integration, governed by an agreement under section 75 of the NHS Act (2006).

4.2 In Croydon, the Better Care Fund is delivered through the One Croydon Alliance. The Alliance is a health and care partnership created from a shared ambition to use Outcomes Based Commissioning and Population Health Management approaches to improve the lives of people in Croydon.

4.3 The Partners in this Alliance are Croydon Council, South West London ICB (Croydon Place), Croydon Health Service NHS Trust, The Croydon GP Collaborative, South London and Maudsley NHS Foundation Trust; and voluntary sector partners including Age UK Croydon.

4.4 The quarterly report provides details on the progress against the previously agreed 23-25 Better Care Fund plan.

5. APPROVAL OF THE QUARTER 23-24 REPORT

5.1 The submission deadline for the quarterly report was 31st October 2024. We were unable to sign-off the submission by the Board prior to submission due to timings of the meetings.

5.2 We were able to agree an interim sign off of the report by the Director of Adult Social Services (DASS) and the Place Based Lead for Health.

6. CONSULTATION

6.2 The 23-24 Quarter 2 report was developed with input from the One Croydon Alliance partners and wider stakeholders in health and social care. The One Croydon Governance was used to agree and implement the schemes as planned.

7. REPORT SUMMARY

7.1 Although the majority of the BCF schemes in 2023-25 were rolled over from 2022-23, the ethos has shifted toward building on the integration work that Croydon has implemented since 2017 to take into account:

- The increased emphasis on providing the right care in the right place at the right time, and improving outcomes for people discharged from hospital via our Croydon LIFE service. Croydon is one of the national Frontrunner sites and the objectives of the programme to transform hospital discharges, align strongly with the BCF objectives;
- The embedding of a neighbourhood approach with our Integrated Care Network Plus (ICN+) model of care in the 6 localities in Croydon working with PCNs to support Croydon people to maintain independence through a proactive and personalised care approach within each of the localities of the borough;
- The additional BCF funding available to support hospital discharges, which has provided the opportunity to increase and align intermediate care capacity in the system in line with the demand and capacity model developed through BCF planning;
- The strengthening of the Croydon frailty and end of life model of care through increased BCF funding and better alignment to ICN+, with acute frailty care strongly joined up with frailty care in the community.
- The significant level of health inequalities experienced in Croydon as highlighted in the Core20+5 analysis and the need to refocus many of the programmes to address inequalities as well as meeting statutory requirements from the Equality Act.

7.2 The BCF and One Croydon Programme are the strong foundations for integrated care in Croydon and help us deliver on our strategic commitments on the sustainability of Croydon's health and care services, delivering care where our population needs it and encouraging healthy lifestyles, as well as recognising the need within our transformational work to reduce avoidable hospital admissions and hospital length of stay.

7.3 Croydon are meeting all of the BCF National conditions for the fund. These are:

- NC1 - A jointly agreed plan between local health and social care commissioners and signed off by the health and wellbeing board

- NC2 - Plans to set out how the services the area commissions will support people to remain independent for longer and, where possible, support them to remain in their own home.
- NC3 - Plans to set out how services the area commissions will support people to receive the right care in the right place at the right time.
- NC4 - Maintaining NHS contribution to adult social care and investment in NHS commissioned out of hospital services.

7.4 Additional findings from the report include:

- **Metrics –** Croydon is currently on track to meet 3/5 national metrics. These are:
  - **Discharge to Normal Place of Residence** – Percentage of people who are discharge from acute Hospital to their normal place of residence 94.1%
  - **Falls –** Emergency admissions as a result of a fall in people aged 65 and over directly aged standardised rate per 100,000. 491.2 per 100,000
  - **Residential Admissions** – Rate of permanent admissions to residential care per 100,000 population (65+).
- **Avoidable admissions** – Croydon have noted the impact of workforce shortages and challenges in recruitment, which has delayed schemes such as the Frailty Front door model. Additionally, the impact of strike actions and exacerbations of LTCs have been a contributing factor.
- **Reablement** – With discharge numbers still high for residents moving from hospital to Pathway 1 and the high acuity needs of these people, reablement services in the community services are put under pressure.

7.5 Guidance & Assumptions – The vast majority of our original demand and capacity estimates have undergone no significant changes. It is believed that the formulas to calculate the demand and capacity are based on sound fundamentals which in themselves did not have to be changed for this revision exercise. Some minor changes applied included:

- The Urgent Community Response figures came back higher than expected. As such these have been adjusted to reflect the increased numbers and reviewing the data to adjust the formulas moving forward.
- It was expected that Pathway1 numbers would increase with the introduction of some specific frontrunner programmes, however, the dates for implementation have been moved back to March 2024. As such the figures have been revised to represent this change.
- Pathway 2 Rehab beds demand has come back slightly lower than predicted over the summer months; however following conversations with stakeholders are going to keep the original estimates for the winter months, as it is expected to revert back to the norm.

8. IMPLICATIONS

8.1 LEGAL IMPLICATIONS

The BCF enables the allocation of grant funding between the Council and SWL ICB. The grant funding sits within the Care Act 2014 and within the 2023-25 BCF policy framework, which requires a signed section 75 agreement between the Council and SWL ICB.

8.2 EQUALITIES IMPLICATIONS

The report has no changes proposed that affect people, policies, facilities, or processes. An equality impact assessment therefore has not been carried out.

9 APPENDICES

A copy of the report is attached.

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Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

1. Guidance for Quarter 2

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities (DLUHC), NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of BCF reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)
2) In Quarter 2 to refresh capacity and demand plans, and in Quarter 3 to confirm activity to date, where BCF funded schemes include output estimates, and at the End of Year actual income and expenditure in BCF plans
3) To provide information from local areas on challenges, achievements and support needs in progressing the delivery of BCF plans, including performance metrics
4) To enable the use of this information for national partners to inform future direction and for local areas to inform improvements

BCF reporting is likely to be used by local areas, alongside any other information to help inform Health and Wellbeing Boards (HWBs) on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICBs, local authorities and service providers) for the purposes noted above.

BCF reports submitted by local areas are required to be signed off by HWBs, including through delegated arrangements as appropriate, as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background and those that are not for completion are in grey, as below:

Data needs inputting in the cell

Pre-populated cells

Not applicable - cells where data cannot be added

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level to between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.

The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste 'Values' only.

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

5. Please ensure that all boxes on the checklist are green before submitting to england.bettercarefundteam@nhs.net and copying in your Better Care Manager.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2023-24 will prepopulate in the relevant worksheets.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the HWB to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2023-25 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

This sheet sets out the four conditions and requires the HWB to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager in the first instance.

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer
National condition 3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time

National condition 4: Maintaining NHS contribution to adult social care and investment in NHS commissioned out of hospital services

4. Metrics

The BCF plan includes the following metrics:
- Unplanned hospitalisations for chronic ambulatory care sensitive conditions,
- Proportion of hospital discharges to a person's usual place of residence,
- Admissions to long term residential or nursing care for people over 65,
- Reablement outcomes (people aged over 65 still at home 91 days after discharge from hospital to reablement or rehabilitation at home), and;
- Emergency hospital admissions for people over 65 following a fall.

Plans for these metrics were agreed as part of the BCF planning process.

This section captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes in the first six months of the financial year.
Data from the Secondary Uses Service (SUS) dataset on outcomes for the discharge to usual place of residence, falls, and avoidable admissions for the first quarter of 2023-24 has been pre populated, along with ambitions for quarters 1-4, to assist systems in understanding performance at HWB level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric ambitions. The options are:

- on track to meet the ambition
- not on track to meet the ambition
- data not available to assess progress

You should also include narratives for each metric on challenges and support needs, as well as achievements.
- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

5. Capacity & Demand Refresh

Please use this section to update both capacity and demand (C&D) estimates for the period November 2023 to March 2024.
This section is split into 3 separate tabs:

5.1 C&D Guidance & Assumptions

Contains guidance notes including how to calculate demand/capacity as well as 6 questions seeking to address the assumptions used in the calculations, changes in the first 6 months of the year, and any support needs and ongoing data issues.

5.2 C&D Hospital Discharge

Please use this section to enter updated demand and capacity related to Hospital Discharge in the bottom two tables. The table at the top then calculates the gap or surplus of capacity using the figures provided. expected capacity and demand from your original planning template has been populated for reference. If estimates for demand and/or capacity have not changed since your original plan, please re enter these figures in the relevant fields (i.e. do not leave them blank).

In Capacity and Demand plans for 2023-24, areas were advised not to include capacity you would expect to spot purchase. This is in line with guidance on intermediate care, including the new Intermediate Care Framework. However, for this exercise we are collecting the number of packages of intermediate/short term care that you expect to spot purchase to meet demand for facilitated hospital discharge. This is being collected in a separate set of fields. You should therefore:

- record revised demand for hospital discharge by the type of support needed from row 30 onwards
- record current commissioned capacity by service type (not including spot purchasing) in cells K22 to O26
- record the amount of capacity you expect to spot purchase to meet demand in cells P22 to T26.

Spot purchased capacity should be capacity that is additional to the main estimate of commissioned/contracted capacity (i.e. the spot purchased figure should not be included in the commissioned capacity figure). This figure should represent capacity that your local area is confident it can spot-purchase and is affordable, recognising that it is unlikely to be best value for money and local areas will be working to reduce this area of spend in the longer term.

5.3 C&D Community

Please use this section to enter updated demand and capacity related to referrals from community sources in the bottom two tables. The table at the top then calculates the gap or surplus of capacity using the figures provided. The same period's figures has been extracted from your planning template for reference.

If estimates for demand and/or capacity have not changed since your original plan, please re enter these figures in the relevant fields (i.e. do not leave them blank).

Data from assured BCF plans has been pre-populated in tabs 5.2 and 5.3. If these do not match with your final plan, please let your BCM and the national team know so that we can update out records and note the discrepancy in your response to question 1 on tab 5.1. Enter your current expected demand and capacity as normal in tabs 5.2 and 5.3.

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

2. Cover

Version 3.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the Better Care Exchange) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Croydon	
Completed by:	Jack Edge	
E-mail:	Jack.edge@swlondon.nhs.uk	
Contact number:	020 7360 9326	
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No	
If no, please indicate when the report is expected to be signed off:	Wed 20/12/2023	<< Please enter using the format, DD/MM/YYYY

Checklist	
	Complete:
	Yes
	Yes
	Yes
	Yes
	Yes
	Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. This does not apply to the ASC Discharge Fund tab.

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5.1 C&D Guidance & Assumptions	Yes
5.2 C&D Hospital Discharge	Yes
5.3 C&D Community	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Croydon

Has the section 75 agreement for your BCF plan been finalised and signed off?	Yes
If it has not been signed off, please provide the date the section 75 agreement is expected to be signed off	

Confirmation of National Conditions			
National Conditions	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in the quarter:**	**Checklist** Complete:
1) Jointly agreed plan	Yes		Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes		Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes		Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes		Yes

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Croydon

National data may be unavailable at the time of reporting. As such, please use data that may only be available system-wide and other local intelligence.

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	For information - Your planned performance as reported in 2023-24 planning				For information - actual performance for Q1	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements - including where BCF funding is supporting improvements.	Checklist Complete:
		Q1	Q2	Q3	Q4					
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	154.0	132.0	165.0	150.0	165.9	Not on track to meet target	There are a number of challenges that the local system is facing, including workforce shortages, impact of strike action and exacerbation of long term conditions. We are aware these are national problems and not just for Croydon, but it is difficult to recruit to new posts at the moment - this in turn is causing a delay to the implementation of new projects or improvement schemes. The frailty frontdoor model for example has been delayed significantly due to delays in recruitment and the model is not fully functional yet as there are gaps in the community posts still.	Proactive care model in Croydon – The approach for proactive care in Croydon, which aims to support early holistic assessment and personalised care with residents with multiple LTCs and using / or at risk of using urgent and emergency care services (including health inequalities related needs) is currently being further developed. This builds upon the approach to integrated team working wrapped around patients and general practice in a neighbourhood team with support provided for complex needs as well as signposting to services for self care / self management to minimise over medicalising wider needs. Work is in progress to revise current primary care contractual arrangements for delivery of this approach including development of system wide measures to support clear demonstration in the change in ED usage and admissions. Along side this work, we have also commenced engagement with general practice to understand how we can further shape the approach to MDT working, based upon the principles of Integrated Neighbourhood Teams outlined in the Fuller	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	93.5%	93.6%	93.3%	93.1%	92.80%	On track to meet target	There are still some challenges in gathering local data to understand the flow through the different discharge pathways. Work is underway to review D2A across the whole system and to ensure people are put on the right discharge pathway.	The latest figure (June 2023) is 94.1% and local intelligence suggests we are on track to meet the target having achieved 93.5% in Q1. This is somewhat different from the national reported performance but there is an increasing trend from 92.8% ini April 23 to 93.4% ini May 23 and 94.1% in June 23, which is positive. As part of frontrunner programme to improve hopsital discharges, we are implementing the follow: • A new health led 'wraparound' care service to receive patients upon discharge home from hospital and to provide up to 7 days of recuperation/care before holistically assessing their intermediate care needs • Prototyped the new health led 'wraparound' care service to test different models of the service (e.g., internal staff vs agency staff) • Worked with hospital ward teams to introduce nursing-led morning board rounds leading to higher quality discussions and discharge planning There are some delays in the implementation of the model but we are confident the impact will start to be be felt through winter.	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,607.0	491.2	On track to meet target	There are a number of challenges that the local system is facing, including workforce shortages, impact of strike action and exacerbation of long term conditions. We are aware these are national problems and not just for Croydon, but it is difficult to recruit to new posts at the moment - this in turn is causing a delay to the implementation of new projects or improvement schemes. The frailty frontdoor model for example has been delayed significantly due to delays in recruitment and the model is not fully functional yet as there are gaps in the community posts still.	Local data has shown that emergency admissions due to falls has decreased compared to prepandemic numbers (308 in Q1 2019/20 vs 233 in Q1 2023/24). For the same quarter, the numbers are decreasing every year. BCF funds Community Falls team and well as supporting independence services and home modifications in the DFG programme. A review of falls services is planned as part of the local implementation of the SWL ICB Frailty model this includes: o Development of an innovative post falls vision pathway – working with local optometrists and AgeUK Croydon to ensure that residents are able to access enhanced vision tests following a fall. This is in addition to a repeated standard vision test already available – with the aim of testing wider vision fields than currently available. The aim is to test the pathway, in order to support early identification of vision defects which may be addressed in primary care by optometrists, through referral to community vision services or highlight other needs. Referral through AgeUK existing services (including falls prevention) supports	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				540		On track to meet target	There continues to be a high number of permanent admissions into residential care either from Discharge To Assess or community referrals. Whilst partners follow the home first principals there is a number of residents with high acuity needs.	Whilst the numbers are still high we have had the following successes through the use of the Adult Social Care Discharge Fund 1) Increase number of social workers in hospital to support Home First policy 2) 11 step down beds to come online from 1 October 2023 to support 28 day step down back home to focus on social care needs. 3) A clear tracking system out of hospital to support residents getting to their long term care destination and focusing on independence and long term care.	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services				96.0%		Not on track to meet target	There is still a high number of discharges from hoispital on pathway 1 and people with high acuity needs coming into the reablement services which is putting pressures on community services to reablle.	Croydon has been selected as a national pilot under the Frontrunner programme. It has trialled a prototype Wraparound/recovery 7 day service so residents get early intervention from all relevant services and daily community MDTS which will be extended further into September and October. The Council has also launched a triage team to support on ensuring good quality referrals being sent to the relevant pathways to help ensure that the right care is in place at point of discharge.	Yes

Better Care Fund 2023-24 Capacity & Demand Refresh

5. Capacity & Demand

Selected Health and Wellbeing Board: Croydon

5.1 Assumptions

	Checklist Complete:
1. How have your estimates for capacity and demand changed since the plan submitted in June? Please include how learning from the last 6 months was used to arrive at refreshed projections?	
The vast majority of our original demand and capacity estimates have undergone no significant changes. The differences seen within 5.2 and 5.3 of this document are within the original margins of error that was applied and therefore have remained unchanged. We believe that the formulas to calculate the demand and capacity are based on sound fundamentals which in themselves did not have to be changed for this revision exercise.	Yes
2. Please outline assumptions used to arrive at refreshed projections (including to optimise length of stay in intermediate care and to reduce overprescription of care). Please also set out your rationale for trends in demand for the next 6 months (e.g how have you accounted for demand over winter?)	
Demand:	
Regarding Pathway 1, the programme team initial predicted that with the introduction of the Frontrunner programme we would see an increase in demand, specifically from Croydon University hospital and mainly through pathway 1, starting from October 2023. As stated above this change did not take place and as such we have revised the demand figures from October to revert back to the original formula that was used to predict the first 6 months demand.	Yes
Capacity:	
As with the pathway 1 demand statement above, Croydon place was expecting to see an increase in capacity, specifically from Croydon University hospital and mainly through pathway 1, starting from October 2023. Once again this change did not take place and as such, we have revised the demand figures from October to revert back to the original formula that was used to predict the first 6 months demand.	Yes
3. What impact have your planned interventions to improve capacity and demand management for 2023-24 had on your refreshed figures? Has this impact been accounted for in your refreshed plan?	
Croydon place has an ongoing programme of looking at different interventions that would either increase capacity or lower demand, most of these interventions have been scoped out within the original BCF demand and capacity estimates and have been accounted for within the original figures.	Yes
4. Do you have any capacity concerns or specific support needs to raise for the winter ahead?	
Croydon Place is currently finding that capacity to deliver is being stretched with additional reporting and governance requirements .i.e. fortnightly discharge report and BCF reporting. Furthermore workforce vacancies and sickness is a concern, especially in general practice and LIFE (D2A) team. This coupled with a lack of winter funding for primary care have raised some concerns for the winter ahead.	Yes
5. Please outline any issues you encountered with data quality (including unavailable, missing, unreliable data).	
There are some minor data quality concerns however all of the concerns can be mitigated with triangulated data. Ongoing work is underway to improve the data quality used.	Yes
6. Where projected demand exceeds capacity for a service type, what is your approach to ensuring that people are supported to avoid admission to hospital or to enable discharge?	
Currently Croydon Place is not expecting any demand to exceed capacity, as this point.	Yes

Guidance on completing this sheet is set out below, but should be read in conjunction with the separate guidance and question & answer document

5.1 Assumptions

The assumptions box has been updated and is now a set of specific narrative questions. Please answer all questions in relation to both hospital discharge and community sections of the capacity and demand template.

You should reflect changes to understanding of demand and available capacity for admissions avoidance and hospital discharge since the completion of the original BCF plans, including

- actual demand in the first 6/7 months of the year
- modelling and agreed changes to services as part of Winter planning or following the Market Sustainability and Improvement Fund announcement
- Data from the Community Bed Audit
- Impact to date of new or revised intermediate care services or work to change the profile of discharge pathways.

5.2 and 5.3 Summary Tables

The tables at the top of the next two tabs show a direct comparison of the demand and capacity for each area, by showing = (capacity) – (demand). These figures are pre-populated from the previous template as well as calculating new refreshed figures as you complete the template below. **Negative figures show insufficient capacity and positive figures show that capacity exceeds demand.**

5.2 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record their refreshed expectations of monthly demand for supported discharge by discharge pathway.

Data from the previous capacity and demand plans will be auto-populated, split by trust referral source. You will be able to enter your refreshed number of expected discharges from each trust alongside these. The first table may include some extra rows to allow for areas who are recording demand from a larger number of referral sources. If this does not apply to your area, please ignore the extra lines.

This section in the previous template asked for expected demand for rehabilitation and reablement as two separate figures. It was found that, by and large, this did not work well for areas so the prepopulated figures for these service types have been combined into one row. Please enter your refreshed expectations for rehabilitation and reablement as one total figure as well.

Virtual wards should not be included in intermediate care capacity because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, please select the relevant trust from the list.

From the capacity and demand plans collected in June 2023, it emerged that some areas had difficulty with estimating demand and capacity for Pathway 0 (social support). By social support, we are referring to lower level support provide outside of formal rehabilitation and reablement or domiciliary care. This is often provided by the voluntary and community sector. Demand estimates for this service type should only include discharges on Pathway 0 that require some level of commissioned low-level support and not all discharges on Pathway 0. If it is not possible to estimate figures in relation to this please put 0 rather than defaulting to all Pathway 0 discharges.

5.2 Capacity - Hospital Discharge

This section collects refreshed expectations of capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Social support (including VCS) (pathway 0)
- Reablement & Rehabilitation at home (pathway 1)
- Short term domiciliary care (pathway 1)
- Reablement & Rehabilitation in a bedded setting (pathway 2)
- Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)

The recently published Intermediate Care Framework sets out guidance on improving capacity, and use of this capacity. You should refer to this in developing your refreshed BCF Capacity and Demand plans.

As with the 2023-24 template, please consider the below factors in determining the capacity calculation. Typically, this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay.

Caseload (No. of people who can be looked after at any given time).

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility.

Please consider using median or mode for Length of Stay where there are significant outliers.

Peak Occupancy (percentage) - What was the highest levels of occupancy expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

The template now asks for the amount of capacity you expect to secure through spot purchasing. This should be capacity that is additional to the main estimate of commissioned/contracted capacity (i.e. the spot purchased figure should not be included in the commissioned capacity figure). This figure should represent capacity that your local area is confident it can spot-purchase and is affordable, recognising that it may impact on people's outcomes and is unlikely to be best value for money and local areas will be working to reduce this area of spend in the longer term.

5.3 Demand - Community

This section collects refreshed expectations of demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. As with the previous template, referrals are not collected by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the 2023-25 Planning Requirements.

The units can simply be the number of referrals.

As with all other sections, figures from the 2023-24 template will be auto-populated into this section.

5.3 Capacity - Community

This section collects refreshed expectations of capacity for community services. You should input the expected available capacity across health and social care for different service types. As with the hospital discharge sheet, data entered in the assured BCF plan template has been prepopulated for reference. You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to
support recovery, including Urgent Community Response and VCS support. The template is split into these types of service:

Social support (including VCS)

Urgent Community Response

Reablement & Rehabilitation at home

Reablement & Rehabilitation in a bedded setting

Other short-term social care

Please see the guidance on 'Demand – Hospital Discharge' for information on why the capacity and demand estimates for rehabilitation and reablement services is now being collected as one combined figure. Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay.

Caseload (No. of people who can be looked after at any given time).

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility.

Please consider using median or mode for Length of Stay where there are significant outliers.

"Peak Occupancy (percentage) - What was the highest levels of occupancy expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services."

Complete:

Better Care Fund 2023-24 Capacity & Demand Refrresh

5. Capacity & Demand

Selected Health and Wellbeing Board: Croydon

Hospital Discharge

Capacity - Demand (positive is Surplus)	Previous plan					Refreshed capacity surplus. Not including spot purchasing					Refreshed capacity surplus (including spot puchasing)				
	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS) (pathway 0)	-1	8	0	5	9	-1	8	0	5	9	-1	8	0	5	9
Reablement & Rehabilitation at home (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Short term domiciliary care (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	98	98	99	98	99	-5	-5	-4	-5	-4	-5	-5	-4	-5	-4
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	0	0	6	5	6	6	6	6	6	6	6	6	6	6	6

Capacity - Hospital Discharge

Service Area	Metric	Prepopulated from plan:					Refreshed planned capacity (not including spot purchased capacity					Capacity that you expect to secure through spot purchasing					Checklist Complete:
		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Social support (including VCS) (pathway 0)	Monthly capacity. Number of new clients.	50	50	50	50	50	50	50	50	50	50	0	0	0	0	0	Yes
Reablement & Rehabilitation at home (pathway 1)	Monthly capacity. Number of new clients.	589	589	596	590	609	386	346	356	356	363	0	0	0	0	0	Yes
Short term domiciliary care (pathway 1)	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly capacity. Number of new clients.	122	123	125	123	125	122	123	125	123	125	0	0	0	0	0	Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly capacity. Number of new clients.	0	0	14	13	14	14	14	14	14	14	0	0	0	0	0	Yes

Demand - Hospital Discharge

Pathway	Trust Referral Source	Prepopulated from plan:					Please enter refreshed expected no. of referrals:					Checklist
		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Social support (including VCS) (pathway 0)	**Total**	**51**	**42**	**50**	**45**	**41**	**51**	**42**	**50**	**45**	**41**	
	CROYDON HEALTH SERVICES NHS TRUST	51	42	50	45	41	51	42	50	45	41	Yes
	(blank)											Yes
	(blank)											Yes
	(blank)											Yes
	(blank)											Yes
	(blank)											Yes
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	(blank)											Yes
Reablement & Rehabilitation at home (pathway 1)	**Total**	**589**	**589**	**596**	**590**	**609**	**386**	**346**	**356**	**356**	**363**	Yes
	CROYDON HEALTH SERVICES NHS TRUST	377	377	381	377	390	247	221	228	228	232	Yes
	EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	24	24	24	24	24	15	14	14	14	14	Yes
	KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	47	47	48	47	49	31	27	28	28	29	Yes
	OTHER	82	82	83	83	85	54	49	50	50	51	Yes
	ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	59	59	60	59	61	39	35	36	36	37	Yes
	(blank)											Yes
	(blank)											Yes
	(blank)											Yes
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	(blank)											Yes
Short term domiciliary care (pathway 1)	**Total**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	Yes
	(blank)											Yes
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Reablement & Rehabilitation in a bedded setting (pathway 2)	**Total**	**24**	**25**	**26**	**25**	**26**	**127**	**128**	**129**	**128**	**129**	Yes
	CROYDON HEALTH SERVICES NHS TRUST	19	20	21	20	21	19	20	21	20	21	Yes
	EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	1	1	1	1	1	104	104	104	104	104	Yes
	KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	1	1	1	1	1	1	1	1	1	1	Yes
	OTHER	2	2	2	2	2	2	2	2	2	2	Yes
	ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	1	1	1	1	1	1	1	1	1	1	Yes
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Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	**Total**	**0**	**0**	**8**	**8**	**8**	**8**	**8**	**8**	**8**	**8**	Yes
	CROYDON HEALTH SERVICES NHS TRUST	0	0	8	8	8	8	8	8	8	8	Yes
	(blank)											Yes
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Better Care Fund 2023-24 Capacity & Demand Refresh

5. Capacity & Demand

Selected Health and Wellbeing Board: Croydon

Community	Previous plan					Refreshed capacity surplus:				
Capacity - Demand (positive is Surplus)	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	4	4	4	4	4	4	4	4	4	4
Urgent Community Response	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting	-4	-4	-4	-4	-4	0	0	0	0	0
Other short-term social care	2	2	2	2	2	2	2	2	2	2

Capacity - Community		Prepopulated from plan:					Please enter refreshed expected capacity:				
Service Area	**Metric**	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.	81	81	81	81	81	81	81	81	81	81
Urgent Community Response	Monthly capacity. Number of new clients.	362	468	374	381	406	416	538	430	438	467
Reablement & Rehabilitation at home	Monthly capacity. Number of new clients.	135	135	135	134	135	89	89	89	89	89
Reablement & Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	4	4	4	4	4
Other short-term social care	Monthly capacity. Number of new clients.	2	2	2	2	2	2	2	2	2	2

Demand - Community	Prepopulated from plan:					Please enter refreshed expected no. of referrals:				
Service Type	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	77	77	77	77	77	77	77	77	77	77
Urgent Community Response	362	468	374	381	406	416	538	430	438	467
Reablement & Rehabilitation at home	135	135	135	134	135	89	89	89	89	89
Reablement & Rehabilitation in a bedded setting	4	4	4	4	4	4	4	4	4	4
Other short-term social care	0	0	0	0	0	0	0	0	0	0

Checklist Complete:
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes

LONDON BOROUGH OF CROYDON

REPORT:	**Health and Wellbeing Board**	
DATE OF DECISION	**Wednesday 24 January 2024**	
REPORT TITLE:	**Frontrunner programme update**	
CORPORATE DIRECTOR / DIRECTOR:	**Matthew Kershaw, Chief Executive, Croydon Health Services and Executive Place Based Leader for Health (SWL ICB, Croydon Place) Annette McPartland, Corporate Director, Adult, Social Care and Health, London Borough of Croydon**	
LEAD OFFICER:	**Hilary Williams, Interim Joint Director of Transformation and Commissioning, South West London Integrated Care Board (Croydon) and Croydon Health Services NHS Trust. Laura Jenner, Deputy Director, One Croydon Alliance Programme Management Office. Bianca Byrne, Director of Commissioning, Policy & Improvement, Adult Social Care & Health, London Borough of Croydon**	
LEAD MEMBER:	**Councillor Yvette Hopley**	
DECISION TAKER:	**Health and Wellbeing Board**	
AUTHORITY TO TAKE DECISION:	**Constitution of the London Borough of Croydon - Part 4.L It is a function of the Health and Wellbeing board to encourage, for the purpose of advancing the health and wellbeing of people in Croydon, persons who arrange for the provision of any health or social care services in Croydon.**	
KEY DECISION? [Insert Ref. Number if a Key Decision] ***Guidance**: A Key Decision reference number will be allocated upon submission of a forward plan entry to Democratic Services.*	**No**	**N/A**

CONTAINS EXEMPT INFORMATION? ***(* See guidance)***	**NO**	**Public**
WARDS AFFECTED:	**All**	

1 SUMMARY OF REPORT

1.1 The current and traditional methods of delivering healthcare in Croydon require significant transformation to better enhance the health and wellbeing of our community, moving from crisis orientated delivery to one where the focus is on proactive and preventative models.

1.2 In 2017, the One Croydon Alliance, a partnership involving the NHS in Croydon, Croydon Council, and the local Voluntary and Community Sector (VCS) was formed .to address the challenges posed by an ageing population and to integrate health and social care services for all age groups in the borough.

1.3 The One Croydon Alliance has successfully implemented innovative models of care, including the Living Independently for Everyone (LIFE) service and has also allowed Alliance partners to collaborate on core business functions.

1.4 The recognition of our achievements led us to become a Frontrunner site, one of six sites selected nationally to pioneer radical approaches to hospital discharge and intermediate care provision.

1.5 This report provides an update on the timeline, progress, risk and issues with the Frontrunner programme.

2 RECOMMENDATIONS

The Health and Wellbeing Board is recommended:

2.1 To note the progress made on the Frontrunner Programme to date

2.2 To note the risk and issues with the Frontrunner programme

3 REASONS FOR RECOMMENDATIONS

3.1 This Frontrunner programme is aligned to the strategic decision objectives of this Board, in that having robust integrated Discharge and Recovery services it will support the reduction in health inequalities among certain cohort of our citizens in Croydon

3.2 High Quality Care is optimised through the development of efficient partnerships to support the development of an integrated Discharge and Recovery service where staff to have clear reporting lines, responsibilities, and objectives.

3.3 A key aim of this programme is to maximise the impact of the 'Croydon pound' by treating people in the right setting, reducing the overprovision of care and having clarity on funding arrangements and budgets.

3.4 The structural changes to the Discharge Team, will enable staff to have clear reporting lines, responsibilities, and objectives.

3.5 Through this integrated model of care and service delivery Health and Care Leaders from across the system work will continue to work collaboratively together progress the Frontrunner programme implementation and make decisions collectively.

4 BACKGROUND AND DETAILS

4.1 The current and traditional methods of delivering healthcare in Croydon requires significant transformation to better enhance the health and wellbeing of our community.

4.2 The commitment is to transform the health and care landscape across Croydon from services which are crisis orientated to those with the emphasis is on collaborative, integrated, and proactive care that maintains wellness and independence within the community and prioritises proactive and preventative care.

4.3 In 2017, the One Croydon Alliance, a partnership involving the NHS in Croydon, Croydon Council, and the local Voluntary and Community Sector (VCS) was formed to address the challenges posed by an ageing population and to integrate health and social care services for all age groups in the borough.

4.4 The One Croydon Alliance has successfully implemented innovative models of care, including the Living Independently for Everyone (LIFE) service and has also allowed Alliance partners to collaborate on core business functions.

4.5 The LIFE service comprises an integrated, community-based team consisting of professionals from reablement, rehabilitation, intermediate care, health and social care, clinicians, and colleagues from relevant community organisations.

4.6 In recognition of these achievements, Croydon was selected to be a national Frontrunner site, one of six sites selected to pioneer radical approaches to hospital discharge and intermediate care provision.

4.7 As a Frontrunner site, the aim is to build on the "One team, One name, One resource" approach of the LIFE service

4.8 Reducing hospital occupancy and unnecessary patient length of stay in hospital by: Creating an effective and truly integrated discharge team Improving joint ways of working on the wards.

4.9 Reducing overprovision of ongoing care (placements/POCs) by delivering integrated intermediate care:

4.10 Introducing a 7 day home first service to holistically assess patients' needs following hospital discharge

4.11 Integrating existing reablement and therapy teams

4.12 Improving relationships with domiciliary care agencies to commission outcomes-based care

4.13 Providing effective bedded intermediate care

4.14 This will be achieved by:

4.14.1 Establishing fully integrated teams and roles spanning acute and community care, through the introduction of a Transfer of Care Hub with integrated health and social leadership and pioneering blended roles between social workers and health discharge coordinators, creating integrated, locality based reablement and therapy teams to improve people's independence

4.14.2 Improving discharge pathways to provide high quality and timely support for patients following an acute episode by establishing an integrated MDT-led Home-First team to provide holistic assessments to patients following discharge

4.14.3 Commissioning the optimum number of intermediate care beds to meet the needs of the population and drive excellent outcomes

4.14.4 Integrating IT systems across acute, community and social care through the introduction of Patienteer software

4.14.5 Ensuring alignment and coordination across the system by creating clear oversight, clinical responsibility, ownership and agreed funding approaches.

4.15 The slide pack accompanying this report provides comprehensive detail on the timeline, progress, risk and issues with the Frontrunner programme.

7. CONTRIBUTION TO COUNCIL PRIORITIES

7.1 Outcome 5: Living healthier independent lives,

7.2 We will harness all the skills and experience available to improve health and wellbeing in the borough, enable people to live independently for as long as possible, and keep adults who are at risk of abuse and neglect safe. We will also work to reduce health inequalities and foster a sense of community and civic life.

7.3 Outcome 1: Getting our finances right,

7.4 We will instil financial discipline, make services more efficient and seek to get value for money from every penny of taxpayers' money we spend. We will listen to, respect and work with partner organisations, Croydon's diverse communities, the voluntary sector, and develop our workforce.

8. IMPLICATIONS

8.1 FINANCIAL IMPLICATIONS

8.1.1 Financial implications are currently being developed via the Frontrunner business case with the potential of a £3.2 million saving each year being suggested. Fewer patients requiring ongoing packages of care due to improved intermediate care offer (reablement and therapy)

8.2 LEGAL IMPLICATIONS

8.2.1 To follow

8.3 EQUALITIES IMPLICATIONS

8.3.1 Reducing health inequalities is a key aim of the SWL Integrated Care Partnership Strategy and plans to deliver on this aim will be described in the NHS Joint Forward Plan. A full EQIA has been completed the headlines:

- The program recognises and values same-sex relationships, ensuring that individuals within the LGBTQ+ community receive equal and respectful treatment. Staff training progrmme with a focus on reablement planning and LGBTQ
- Several people accessing the service have Dementia. Therefore, specialist dementia friendly communication resources are being put in place to improve accessibility.
-

9. APPENDICES

9.1 *A* ***Frontrunner: Delivering integrated care in Croydon (One Croydon Alliance)***

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One Croydon Alliance

Frontrunner programme: Delivering integrated care in Croydon

Agenda

- **What we set out to deliver**
- What we've delivered so far
- What's next
- Appendix

Croydon's aim for the Frontrunner programme was to bring together system wide transformation efforts to provide integrated care in Croydon and get people the right care, at right time, in the right place

Aims

Defining effective pathways architecture
Delivering integrated care across our discharge processes by simplifying processes, removing steps, aligning ways of working

Getting the right teams and workforce
Introducing truly integrated teams, blended roles, and providing appropriate capacity and capability

Maximising the impact of the 'Croydon pound'
Treating people in the right setting, reducing overprovision of care, joint fundings and budgets

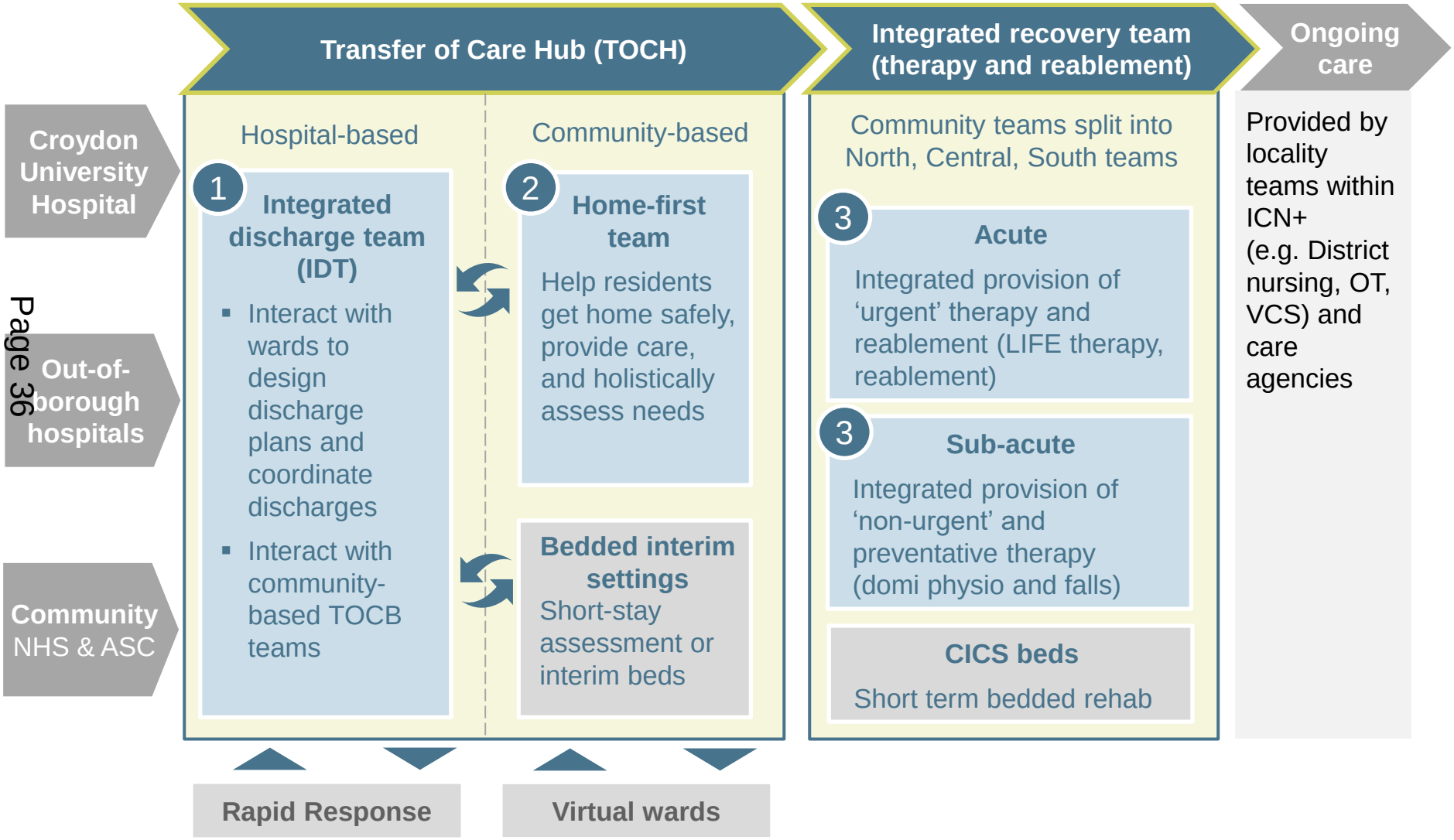
Alignment and coordination across the system
Creating clear oversight, clinical responsibility, ownership and introducing

Improving data capture and information flow
Integrating IT systems, improving accurate data reporting and creating insightful KPIs

Improving the quality of care for people in Croydon by getting people the right care at the right time, in the right place through

The Frontrunner blueprint consists of a Transfer of Care Hub responsible for effectively co-ordinating discharge, and an integrated recovery team

= Focus of blueprint

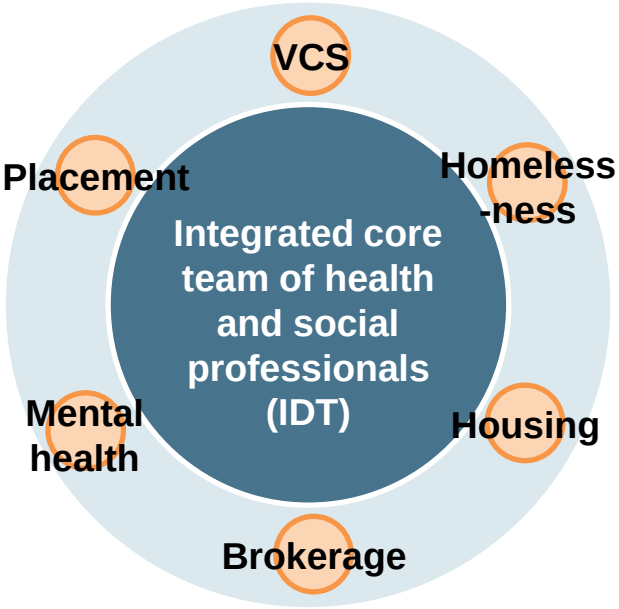


1 Ambition: The IDT is the core of the Transfer of Care Hub (TOCH) – a single point of discharge, responsible for co-ordinating the safe transfer of patients into a D2A setting

= Service representative

CUH ward staff

Interact with ward staff to design discharge plans and coordinate transfer of care



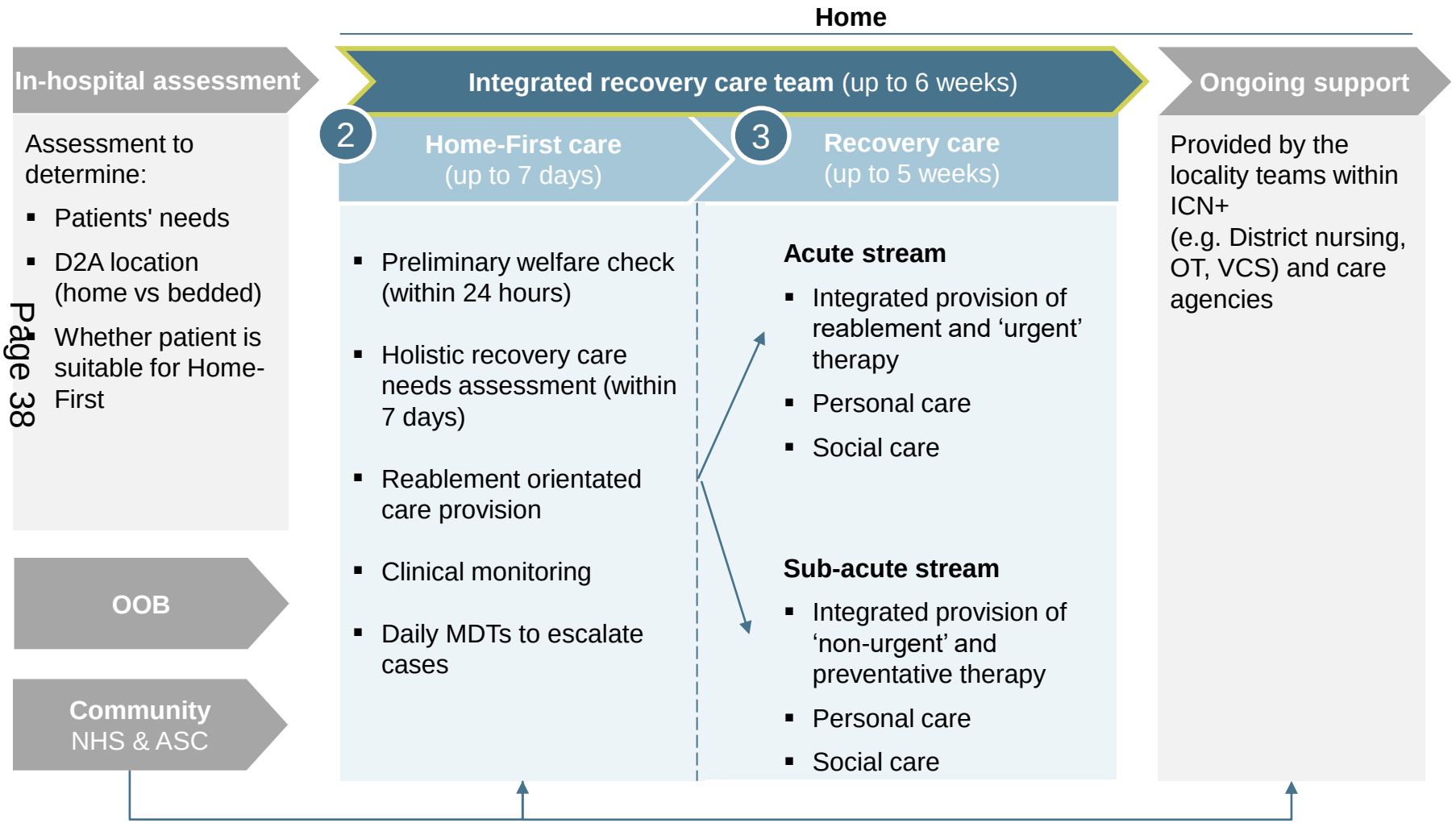
Interact with community providers make pathway decisions, coordinate transfers of care and understand capacity within the community

Home-First and interim beds teams

Underlying principles of the TOCH:

- Integration
- Home first
- Discharge to assess (D2A)
- Trusted assessor
- Promoting independence

2 3 Pathway 1 ambition: Patients discharged home on Pathway 1 will be referred into an 'integrated recovery care team' that provides Home-First care (up 7 days) followed by recovery care

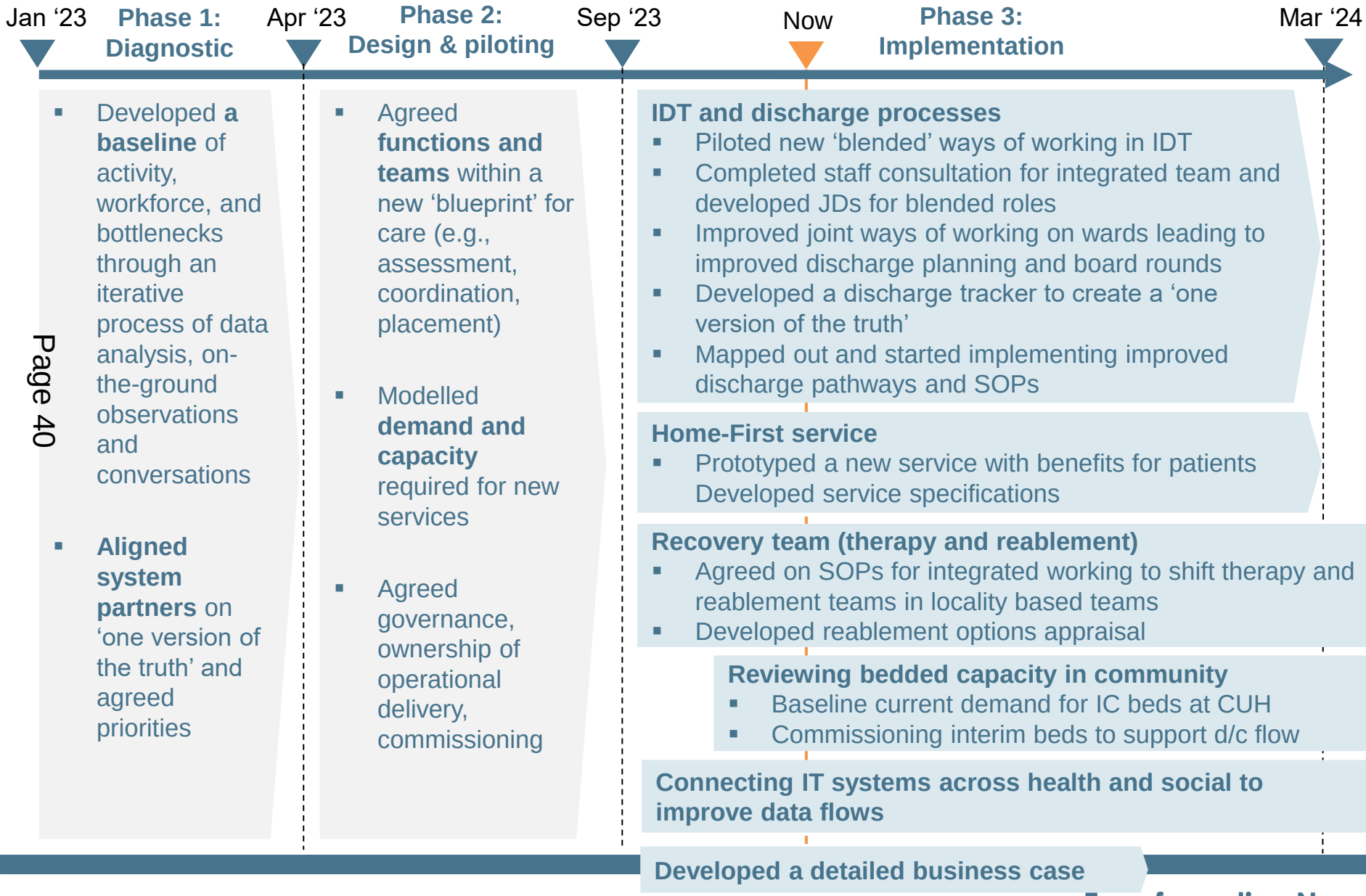


Note: This is the Phase 1 ambition, the long-term ambition is to have integrated North, Central and South community teams

Agenda

- What we set out to deliver
- **What we've delivered so far**
  - IDT and hospital discharge
  - Home-first team
  - Reablement and therapy
- What's next
- Appendix

We are partway through implementing the blueprint for a new model of care and have already made significant progress



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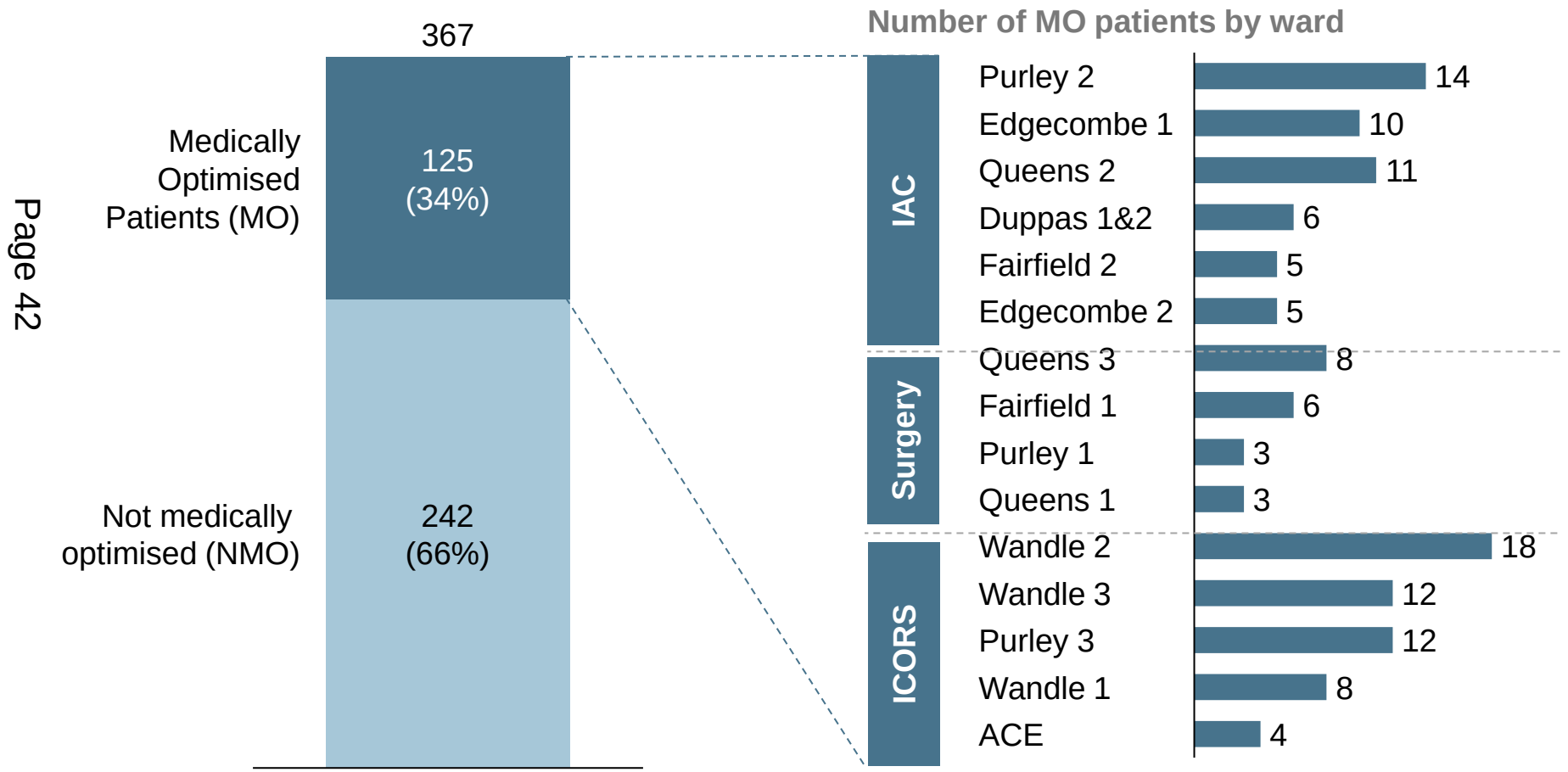
We performed a hospital audit understand the opportunity. 125 out of 367 beds (34%) were occupied by ‘medically optimised’ patients

MO and NMO patients identified across CUH inpatient wards*,

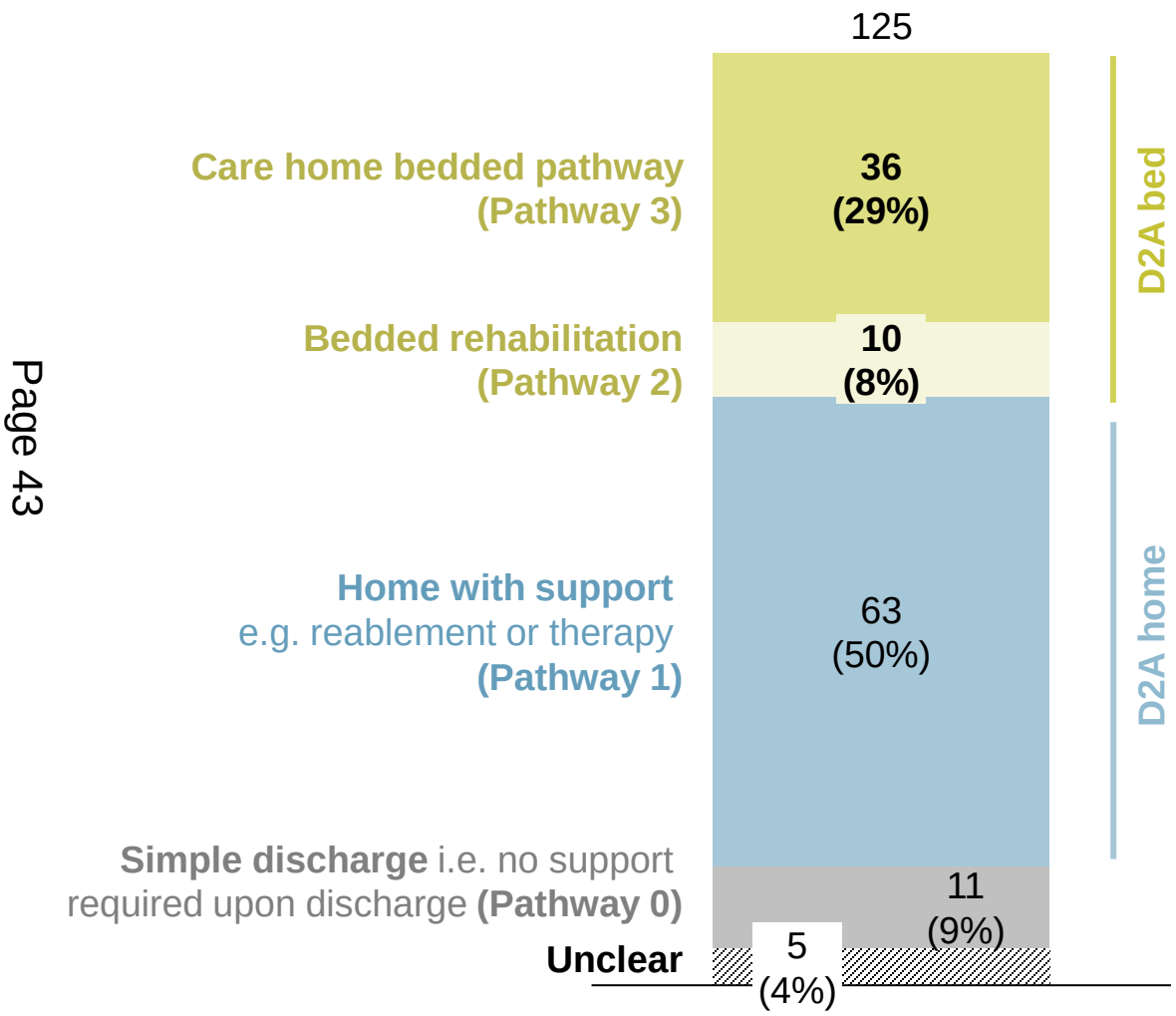
#, 13th November 2023



Source: MO Audit dataset *excludes AMU, Kenley, ADU, CCU

Hospital audit: Of the 125 medically optimised patients, 63 (50%) are waiting for reablement, care or therapy at home (Pathway 1)

MO patients by D2A discharge pathway,
#, 13th November 2023



- There is an 'opportunity' of 125 beds that are not required for acute care
- Unnecessary LoS means that patients cannot move through the hospital and ED becomes congested with long waits
- Unnecessary length of stays also lead to higher risk of patients deteriorating on the wards – which mean patients are discharged with higher needs in the community and have less independence

 Source: MO Audit dataset

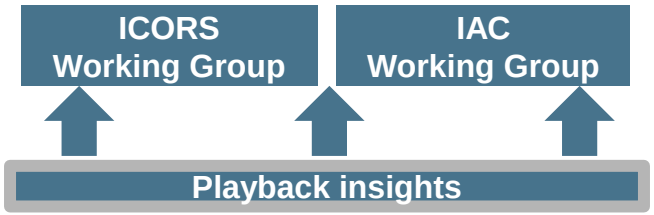
A nursing led improvement workstream piloted improved ways of working on the wards

Objectives:

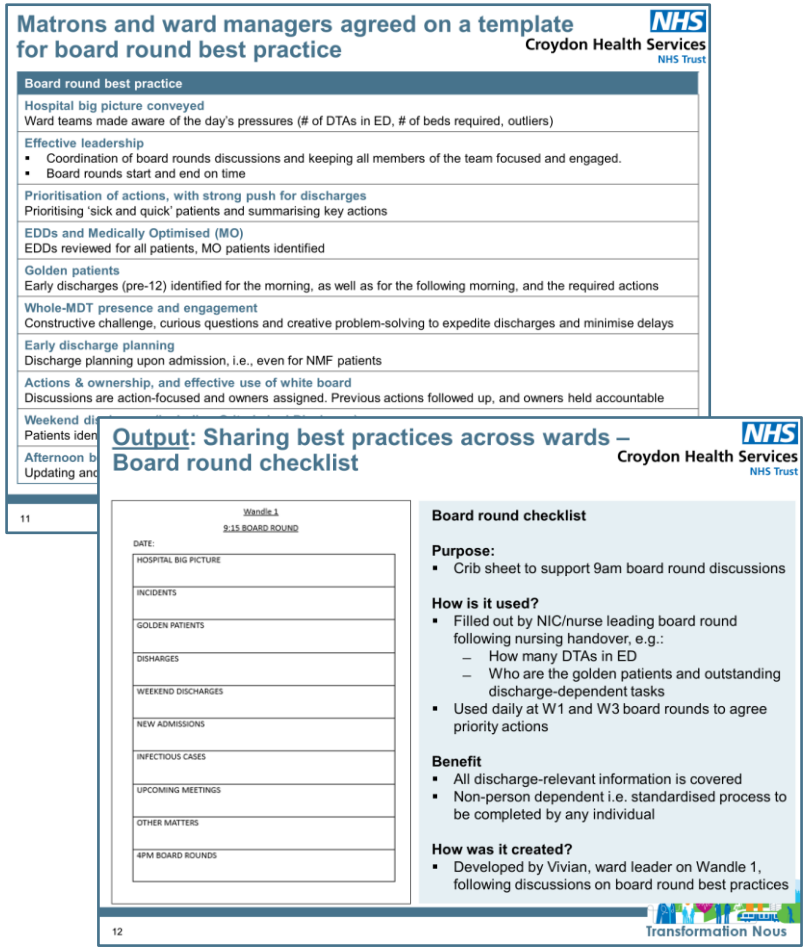
1. Improved early discharge planning and patient ownership
2. Improving joint ways of working (roles and responsibilities, daily structure, comms)
3. Improving discharge coordination

Ways of working:

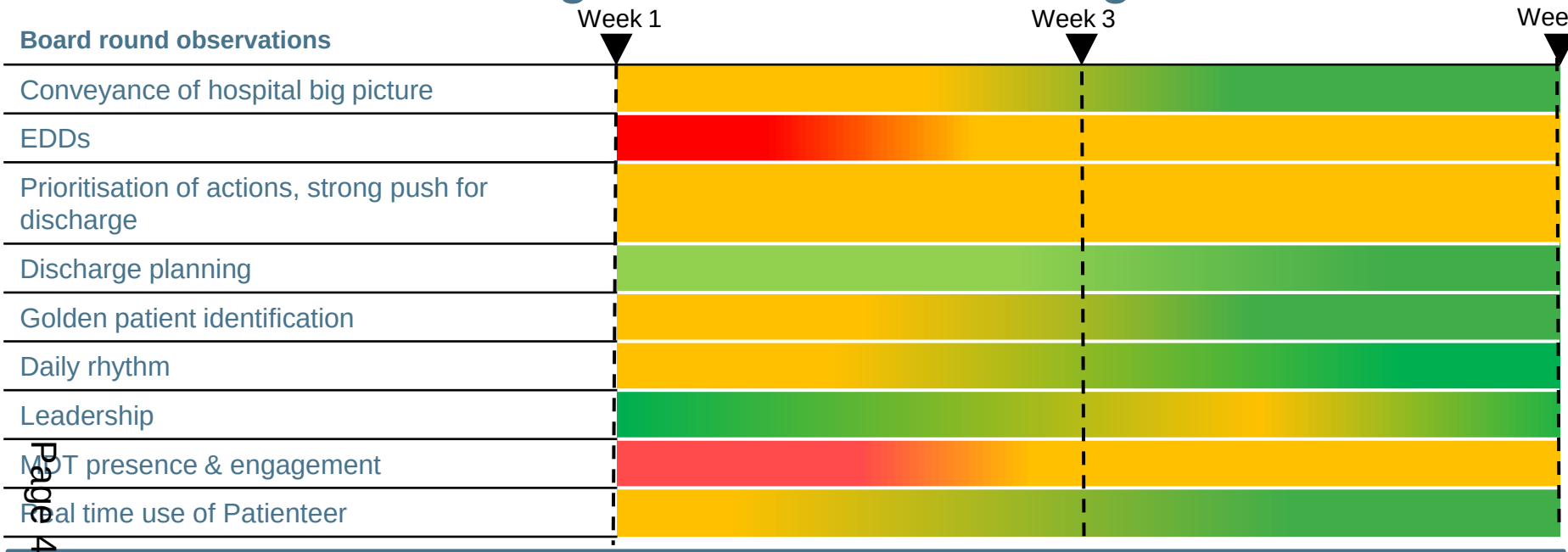
- Observations of ways of working through shadowing and attending board rounds
- Capturing feedback from staff
- Review progress against KPIs
- Weekly working groups attended by nurses, therapy leads, IDT

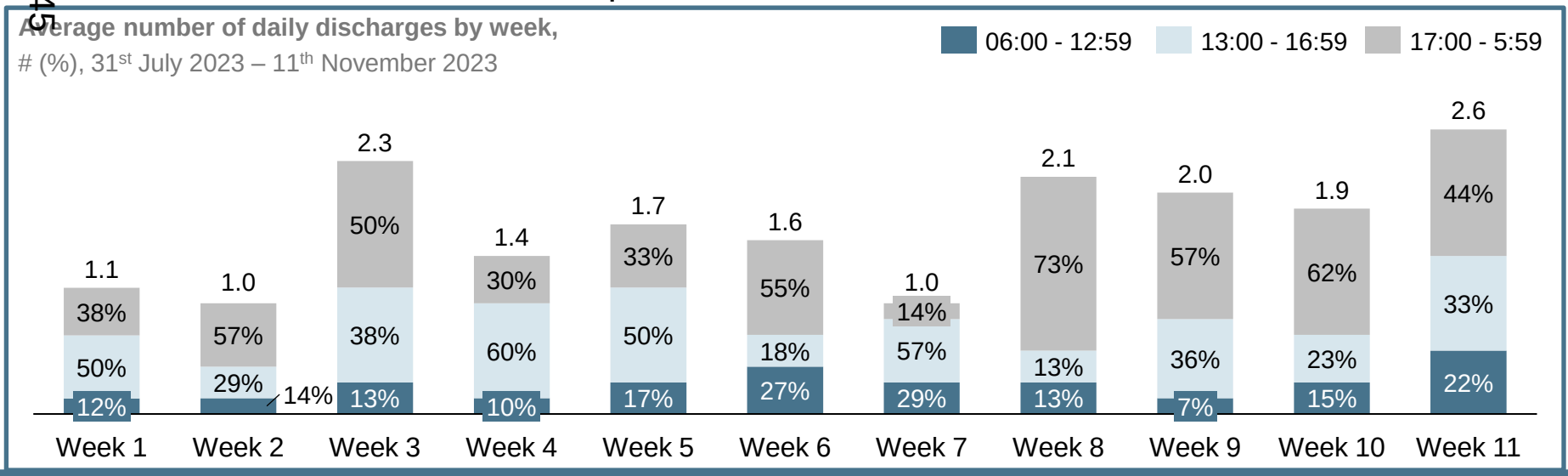


Workstream outputs:



Impact: On pilot wards the board round quality has improved, there are more discharges and earlier discharges





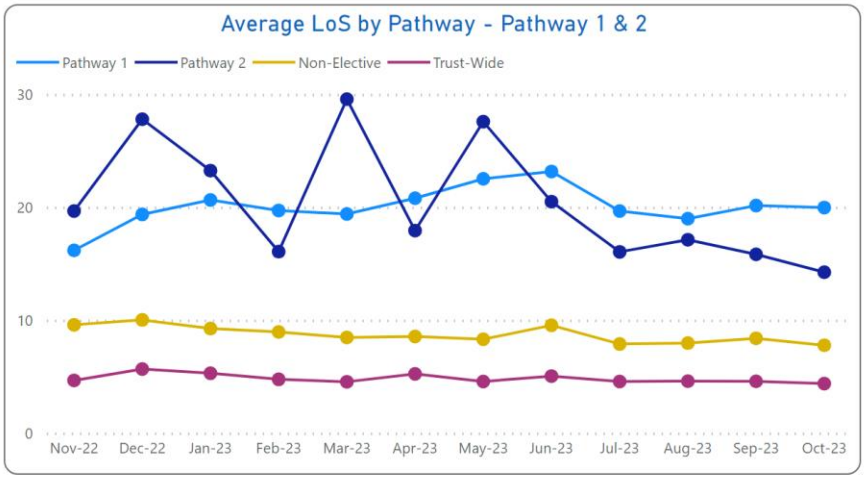
Impact: The average length of stay has dropped on Pathways 0, 2, and 3

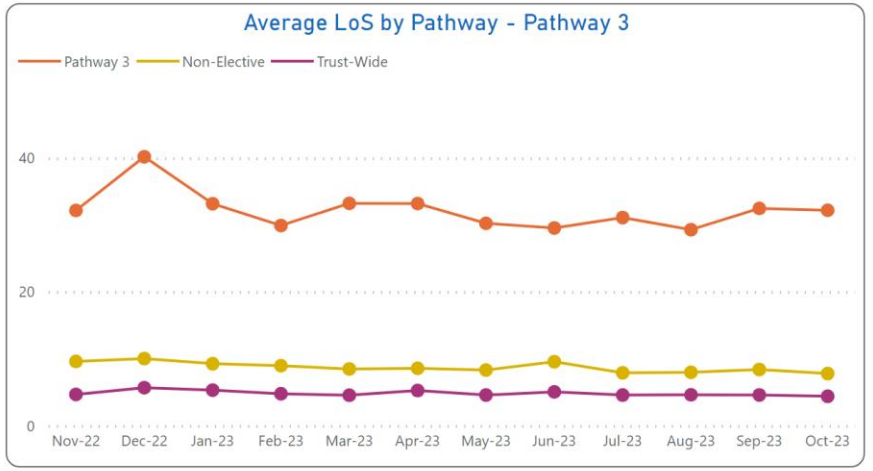
One croydon

Hospital - LoS by Pathways

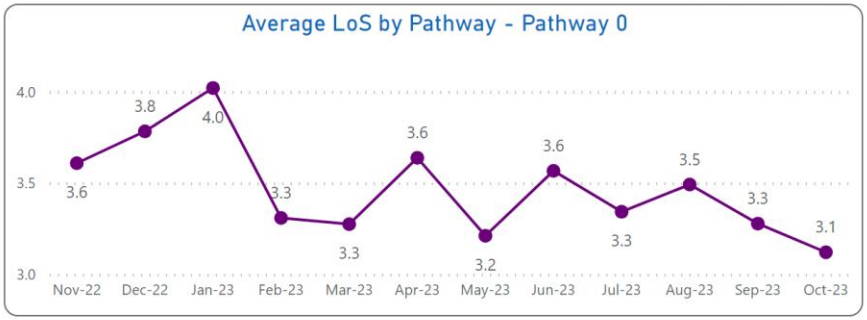
NHS Croydon Health Services NHS Trust

Pathway 1 20.0 | Pathway 2 14.3 | Pathway 3 32.2 | Non-Elective 7.8 | Trust-Wide 4.4





Pathway 0 3.1



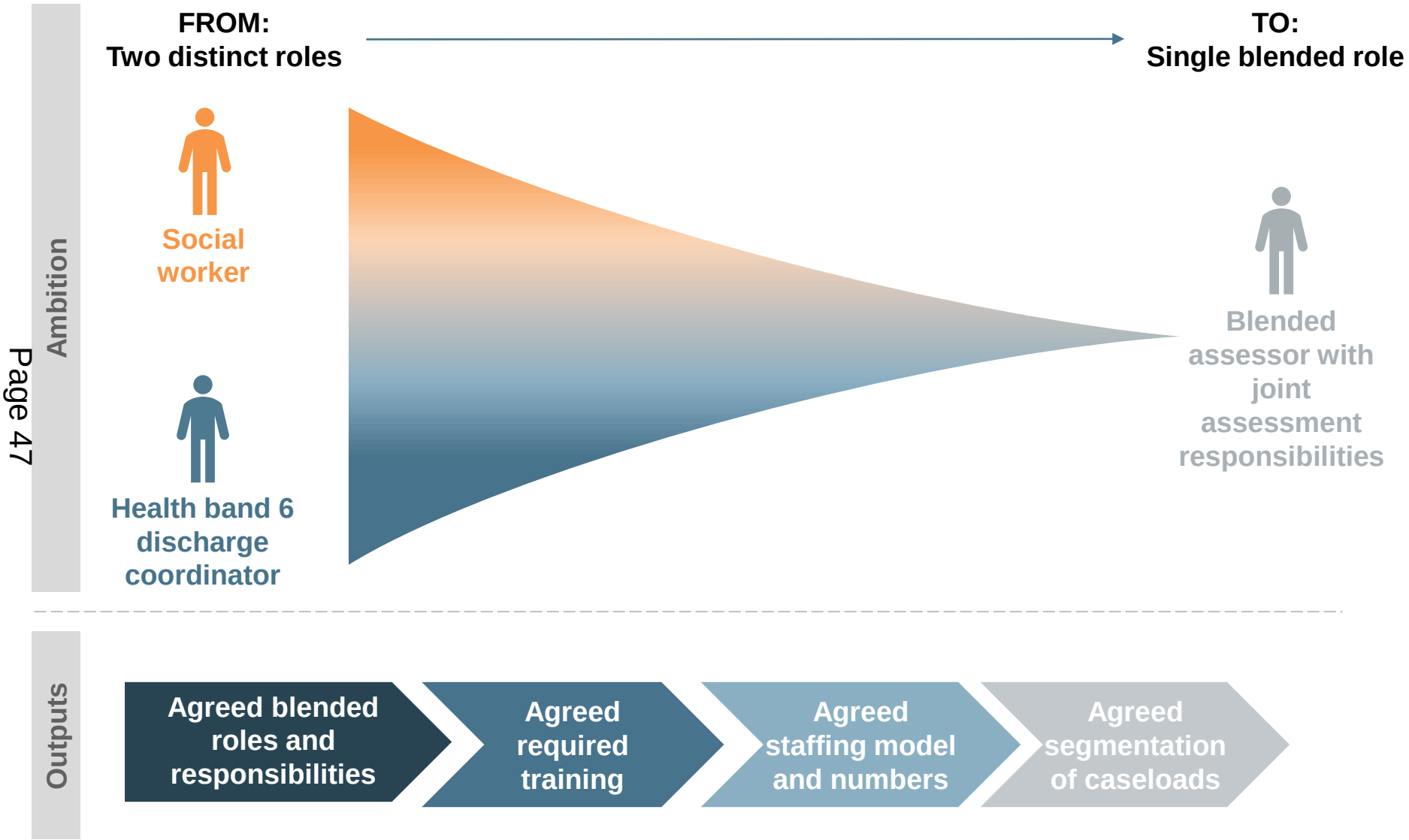
Avg. Daily Discharge & Avg. LoS by Pathway

Month	Aug-23			Sep-23			Oct-23		
Pathway	Avg. LoS	Daily Avg Discharge	Prop.	Avg. LoS	Daily Avg Discharge	Prop.	Avg. LoS	Daily Avg Discharge	Prop.
Pathway 0	3.5	83.9	93.6%	3.3	86.5	93.0%	3.1	82.6	93.2%
Pathway 1	19.0	4.5	5.0%	20.2	5.1	5.4%	20.0	4.9	5.5%
Pathway 2	17.1	0.3	0.3%	15.8	0.4	0.4%	14.3	0.3	0.3%
Pathway 3	29.3	1.0	1.1%	32.5	1.1	1.1%	32.2	0.9	1.0%
Total		89.6	100.0%		93.0	100.0%		88.6	100.0%

Note: The Average LoS on this page includes patients admitted through both elective and emergency routes and zero LoS patients except where stated otherwise.

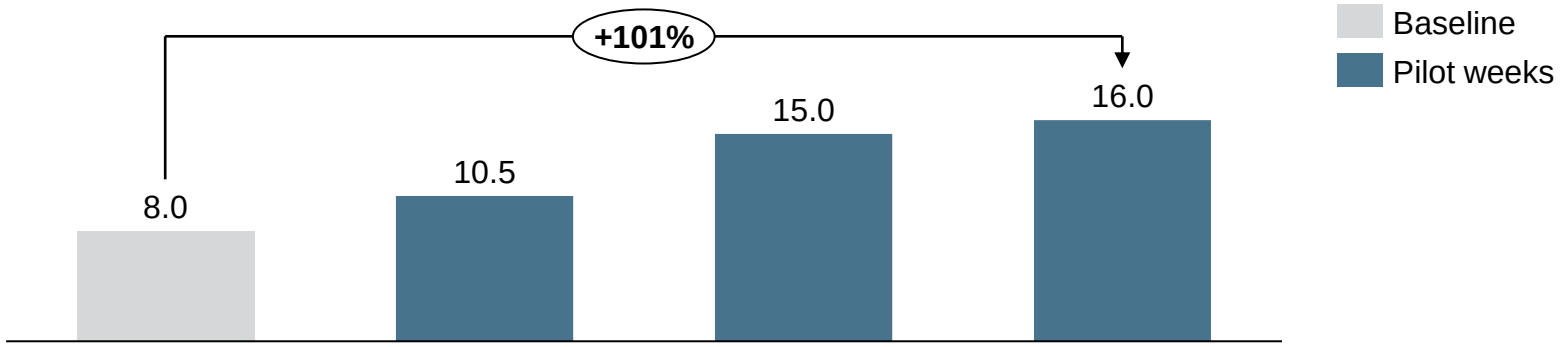
Professional | **Compassionate** | **Respectful** | **Safe**

We conducted a pilot to develop a blueprint for creating a ‘blended assessor’ role within the IDT team



Impact: The pilot of blended roles showed there was improved flow of patients and staff satisfaction

Average weekly discharges from Wandle 2 by week,
Days, #, Oct '22 – Jan '23 & 25th April '23 – 11th May '23



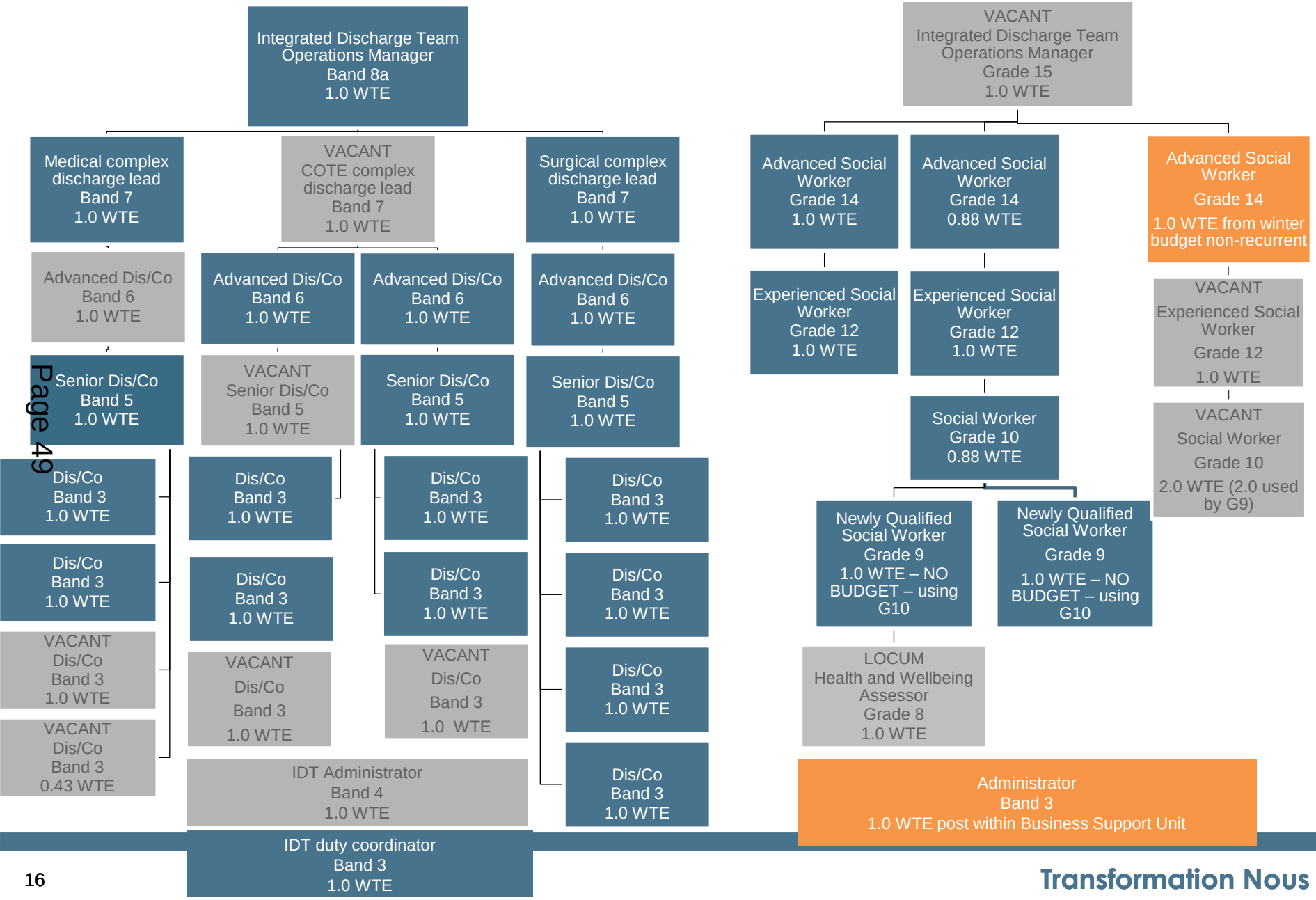
Patient flow

Staff feedback

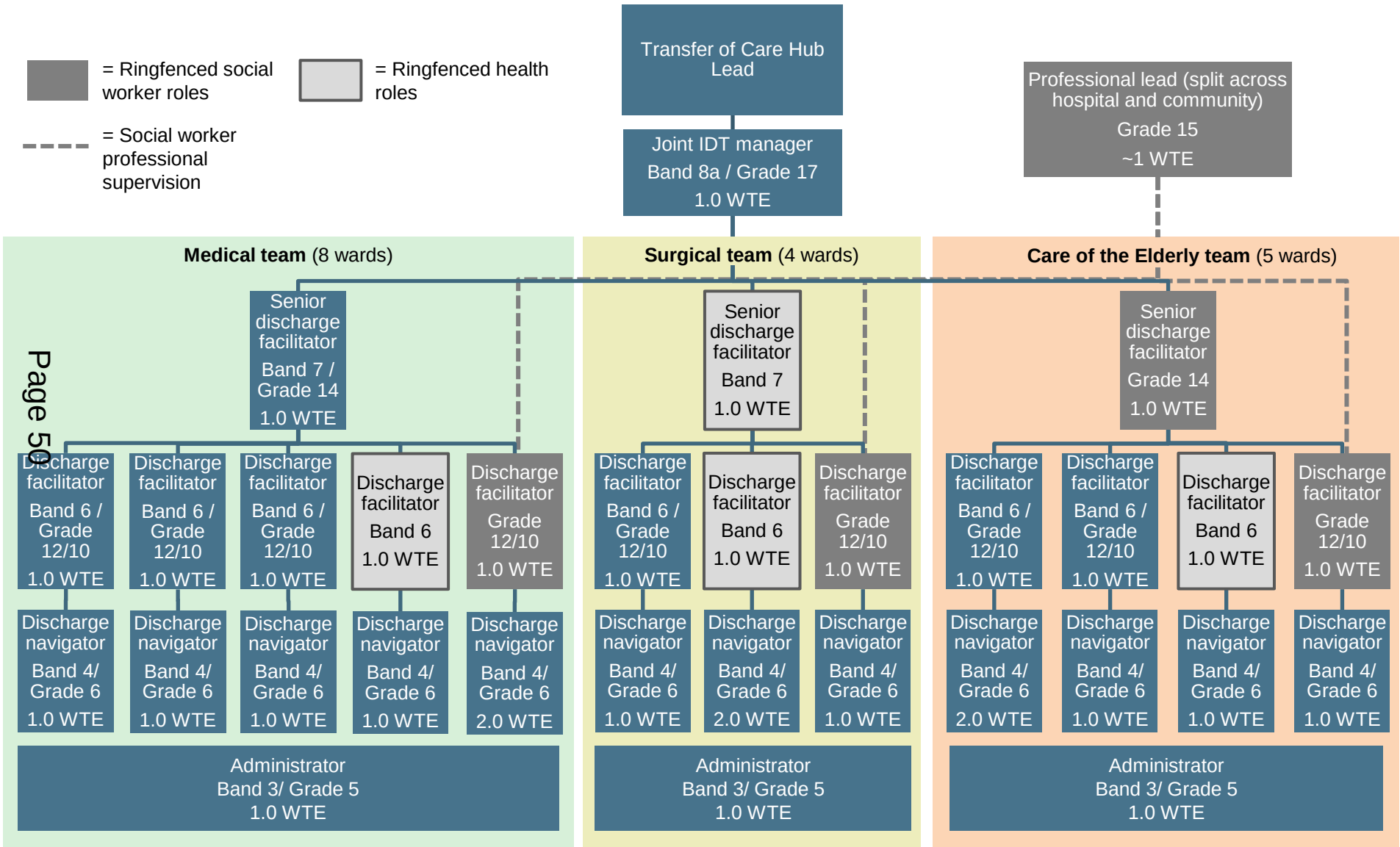
Area	Reflections from IDT staff following the pilot of the blended role
Benefits	▪ IDT members and ward staff have **responded positively to increased IDT presence on the wards** and have seen **improved referral times** ▪ **Collaboration** between the health and social sides of the IDT has improved – *"I didn't really know the discharge coordinator before the pilot – but now we're best friends" – social worker* ▪ IDT staff feel they have **developed professionally and gained confidence** through the pilot
Challenges	▪ IDT staff **don't see the value in the blending** of social workers and Band 6s

▪ CUH daily discharge sitrep & TN data collection

We have completed a consultation to move from an IDT with a split structure (Trust and Council)…



…to an integrated health and social structure



Note: The ringfenced G14 and B7 could be in any of the three teams – they are shown in COTE and Surgery as an example. Similarly the ringfenced B6 and G12/10 roles could be in any of the posts in each team.

To improve variation in assessment practices, we co-developed with teams a single assessment team, developed a joint tracker with agreed KPIs to assess performance

Improving flow and reporting of data in the Integrated Discharge Team:

- ASC and hospital colleagues identified the lack of a 'one version of the truth' on patient flow into the community

What we did

- We co-designed and implemented a joint tracker (for hospital & council teams) that follows Pathway 1 discharges from referral to discharge

Impact

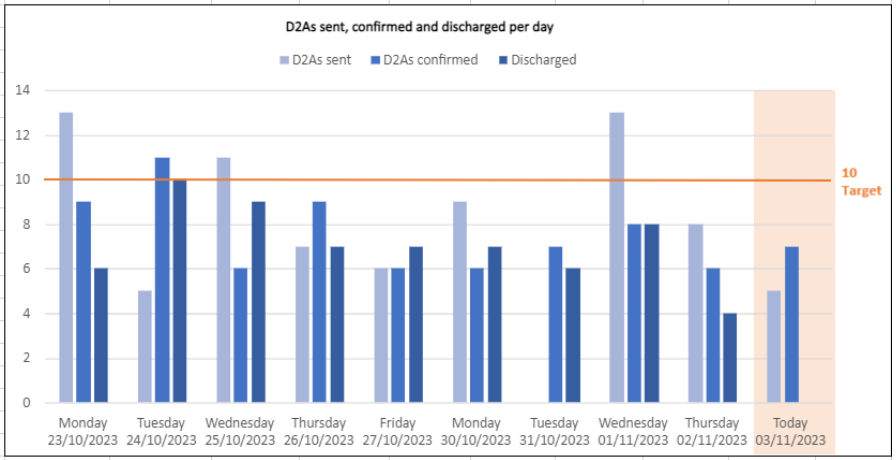
- Head of ASC brokerage – "It's great to have everyone working from a One Version of the Truth"
- Deputy Chief of Operations (CUH) – "Now we can clearly see the failed discharges and get learnings for next time"

Pathway 1 discharge planning

Date and time stamp	11:40 07/12/2023
Total waiting POC	14
Awaiting triage	10
Awaiting brokerage	4

Wednesday 06/12/2023		Today 07/12/2023		Friday 08/12/2023	
Patients discharged yesterday:	0				
Failed discharges	1	POC confirmed and to start today:	0	POCs confirmed and to start next day:	0

Dashboard



Agenda

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- **What we've delivered so far**
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- Appendix

A prototype tested the 'Home First' model to improve outcomes and experiences for Croydon residents

Hospital | **Community**

Previous D2A process

Assessment and referral	Reablement / Rehabilitation	Ongoing care
▪ Part A completed by therapists ▪ Brokerage organises POC	▪ Part B assessment completed within 24 hours ▪ Receive POC/reablement and or rehabilitation ▪ Part C completed once reablement/rehab plan is completed	Provided by ICN+ neighbourhood teams

Home-First prototype model

Assessment and referral	**Home-First** (up to 7 days)	Recovery care	Ongoing care
▪ Part A completed by therapists ▪ Brokerage organises POC	▪ Welfare check within 24 hours ▪ Supported by MDT ▪ Holistic assessment (Part B) following recuperation	▪ Reablement and rehab. provision by LIFE teams ▪ Part C completed	

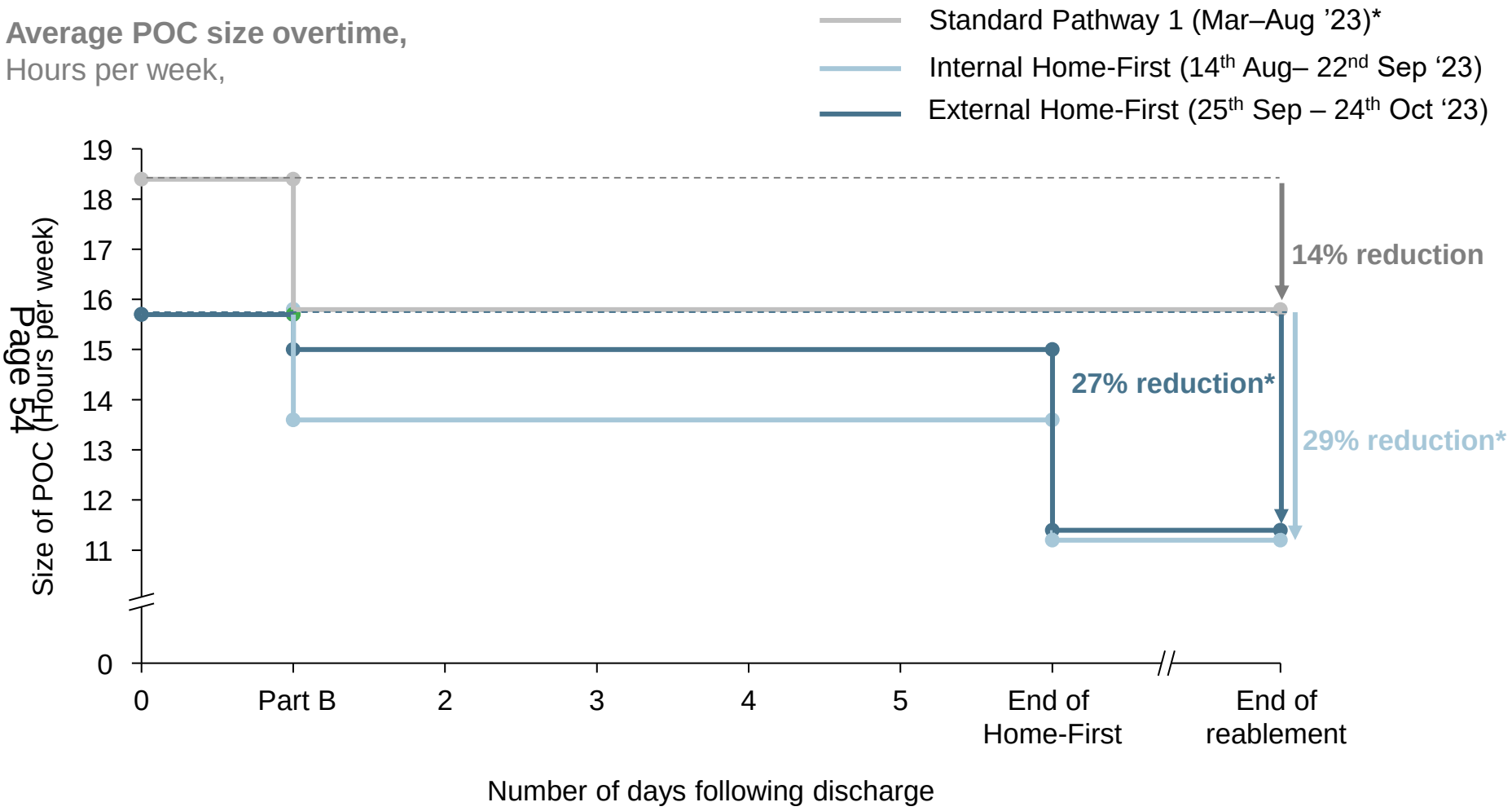
Some residents triaged straight into recovery care

Home-First objectives:

- **Increased resident independence and reduced overprovision of intermediate / ongoing care** as patients are holistically assessed whilst recuperating for up to 7 days
- **Reduced readmissions** due to MDT and Home-First support
- **Reduced length of stay in hospital** due to providing consultants with confidence to discharge to service

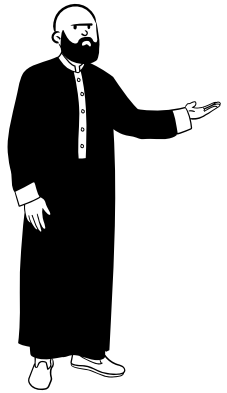
Impact: The Home-First team has resulted in have seen an improvement in the ‘right-sizing’ of care in the days following discharge

Average POC size overtime,
Hours per week,



* Assuming the average visit is 50 mins. 4 external Home-First patients are missing information on POC size

Impact: Jack's case study



Context: Jack is a 66-year-old man who lives in a lower ground floor flat. Prior to his hospital stay, he had been completely independent and had never had a package of care. He enjoys cricket, travel, and his grandchildren.

Timeline summary:

31/08/23	Admission to CUH
15/09/23	Referral to Home-First Service
16/09/23	Discharge from CUH. A&E Liaison Officer, attended for welfare check
17/09/23	Home-first team assessed and put in a plan of action
17/09/23	Equipment delivered (shower stool and walking stick)
20/09/23	Family informed officers Jack was travelling to Jamaica and keen to get better
22/09/23	Jack was supported effectively, he followed his plan, got well and was discharged
23/09/23	Jack was fit enough to fly to Jamaica

Benefits of Home-First care for Jack:

- **Increased independence:** Going to the home-first team for 7 days prevented Jack from receiving a 6 weeks long package of care that he did not require and may have reduced his independence
- **Effective communication with family:** The Home First team worked / communicated effectively with Jack's family to identify tailored goals and work up a plan to help achieve them
- **Personalised care:** By spending the time to get to know Jack and his hobbies, the Home First team was able to align the right member of staff to help achieve his goals
- **Collaborative MDT:** Daily monitoring and discussing of Jack helped put in the right support to reach his goals within 7days

Impact: Home-first staff reflections

MDTs a success & improved:
- Information flow
- Staff confidence
- Shared learning

Great conversations at MDT enhancing staff knowledge on other areas and knowing each other better

Created a mechanism for using resources efficiently

Improved working relationships between all stakeholders especially with our external care providers

make our job enjoyable

This way of working should be encouraged and implemented

Discussing residents in an MDT speeds up care & help us all put robust care plans in place for our residents

Highlighted areas that needs improvement especially communication between all staff

Supported identifying areas of training needs for staff

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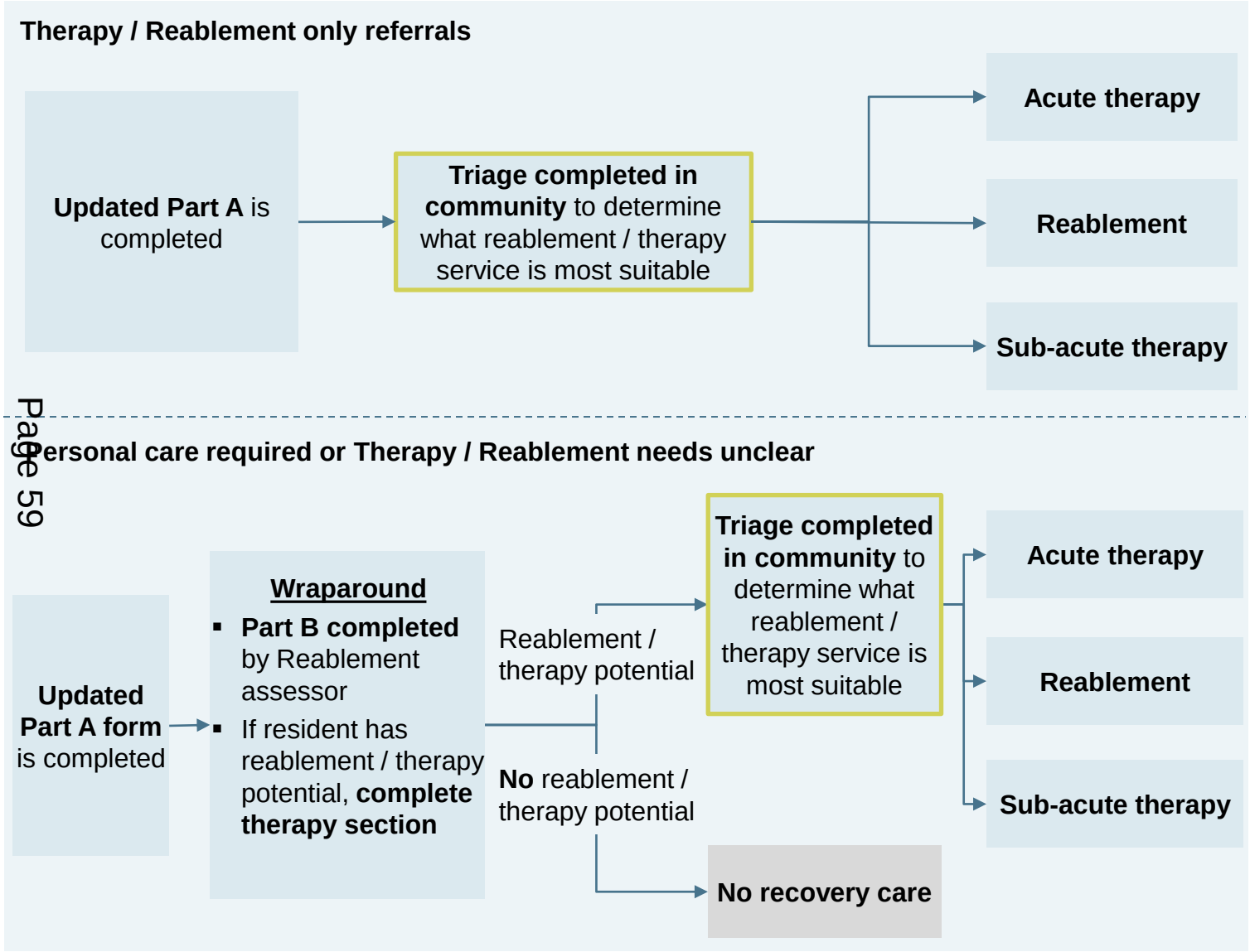
Workstream 3 is integrating six separate therapy and reablement to reduce duplication and siloed working

Reablement (Social)	**Teams** and responsibilities	**1. LIFE Early Reablement:** Complete Part Bs and Cs and offer social support in community	**2. LIFE Reablement and Recovery:** Complete Part Bs and Cs and provide reablement visits	**3. OOB social care:** Complete Part Bs and Cs, offer social support in community and complete in-hospital Pathway 3 assessments
	Workforce	▪ Social workers ▪ Health and wellbeing assessors (HWA)	▪ Senior reablement officers ▪ Reablement officers	▪ Social workers ▪ HWAs
Therapy (Health)	**Teams** and responsibilities	**4. LIFE Therapy:** Provide rehabilitation to patients discharged from CUH	**5. Domi Physio:** Provide rehabilitation to residents in their home	**6. Falls:** Provide rehabilitation to residents that have had a fall
	Workforce	▪ Physios (PTs) ▪ Occupational therapists (OTs) ▪ Therapy assistants (TAs) ▪ HWAs	▪ PTs ▪ TAs	▪ PTs ▪ OTs ▪ TAs ▪ Practitioners

Areas of opportunity for integration:

- **Reablement:**
  - Overlapping responsibilities
  - Different roles with different bandings that have same responsibilities (e.g., HWAs and Senior reablement officers)
- **Therapy:**
  - Multiple triages
  - Different referral forms
- **Reablement and therapy:**
  - Duplication of assessments and visits
  - Different systems (LAS and EMIS)

Impact: We have introduced a joint triage or single point of access into reablement and therapy to reduce duplication



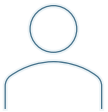
Impact of the new process:

- **Referrals all via SPOA** from any source, uploaded to a main EMIS inbound folder
- **Single referral** will be made, rather than scattergun referrals to each of the existing services
- **Single triage** to determine the best service rather than each team triaging in isolation
- **Same system** would be used by each team leading to better oversight of patients

Impact: We have developed single job descriptions for community assessors to integrate teams and improve standards

FROM: 3 distinct 'reablement assessor' roles

TO: 1 integrated 'Reablement assessor' role



Health and Wellbeing Assessor (Grade 8)

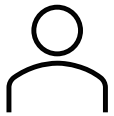
- Responsibilities: Complete Part Bs and Cs, escalate any social/reablement challenges and provide induction and LAS support to new workers
- Employed by the council
- Currently sit within the LIFE early reablement and OOB social care team

Health and Wellbeing Support Worker (Grade 6)

- Responsibilities: Complete Part Bs and Cs and escalate social/reablement challenges
- Employed by the council
- Currently sit within the LIFE early reablement team

Senior Reablement Officer (Grade 7)

- Responsibilities: Complete Part Bs and Cs, escalate any social/reablement challenges and supervise reablement officers
- Employed by the council
- Currently sit within the LIFE recovery and reablement team



Reablement assessor (Grade 8)

- Complete Part Bs and Cs, escalate any social/reablement challenges and supervise reablement officers
- Employed by the council/NHS
- Sitting across the Community Recovery Service

We have developed an options appraisal for reablement considering direct costs, ongoing costs, quality and feasibility of delivery

FOR DISCUSSION

	1	2	3	4
	Fully external *(see page 7)*	**Hybrid: Internal team provide ~15% of reablement** *(see page 8)*	**Hybrid: Internal team provide 50% of reablement** *(see page 9)*	**Fully internal** *(see page 10)*
Description	Reablement provision outsourced to a care agency	▪ Croydon employed staff provide 3 reablement visits each week to reablement only patients (~15%) ▪ Care agency provide remaining reablement	Reablement provision split equally between Croydon employed staff and a care agency	Reablement provided by Croydon employed staff
Annual cost of reablement and assessment	**£2.6 million**	**£3.1 million**	**£4.0 million**	**£6.0 million**
Required staffing	**N/A**	▪ **17 reablement officers** ▪ **1 manager**	▪ **60 reablement officers** ▪ **4 managers**	▪ **120 reablement officers** ▪ **8 managers**
Annual cost of ongoing care	**£6.8 million** (26%* patients require ongoing care)	**£3.7 million** (14%** patients require ongoing care)	**£3.2 million** (12% patients require ongoing care)	**£2.6 million** (10% patients require ongoing care)
Implications	▪ Lose the existing high quality internal reablement team ▪ Need to incentivise care agencies to provide reablement	Need to incentivise care agencies to provide reablement focused care	▪ Need to incentivise care agencies to provide reablement focused care ▪ Additional funding required for estates	▪ Potential drop in quality of reablement when managing a large team ▪ Additional funding required for estates

Note: Cost of assessment is not included – required capacity is already within the system so no additional funding is required

*Current outcomes of external reablement
** Current outcomes of internal reablement

Agenda

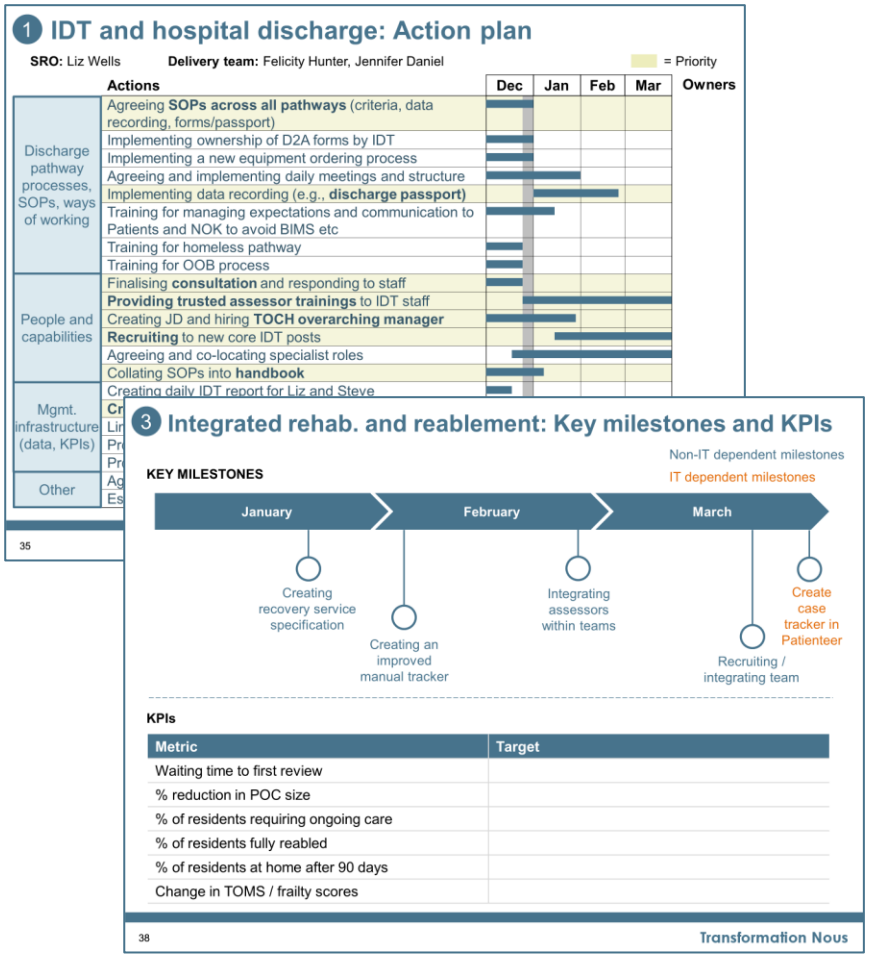
- What we set out to deliver
- What we've delivered so far
- **What's next**
- Appendix

There is still a way to go on our transformation journey. To support the ongoing implementation, we have developed action plans and clear governance for each workstream

Each workstream lead has developed:

- High level workstream milestones to measure success against
- Clear workstream action plans with assigned owners and timelines
- Regular reporting and governance routes
- Agreed KPIs to monitor progress against

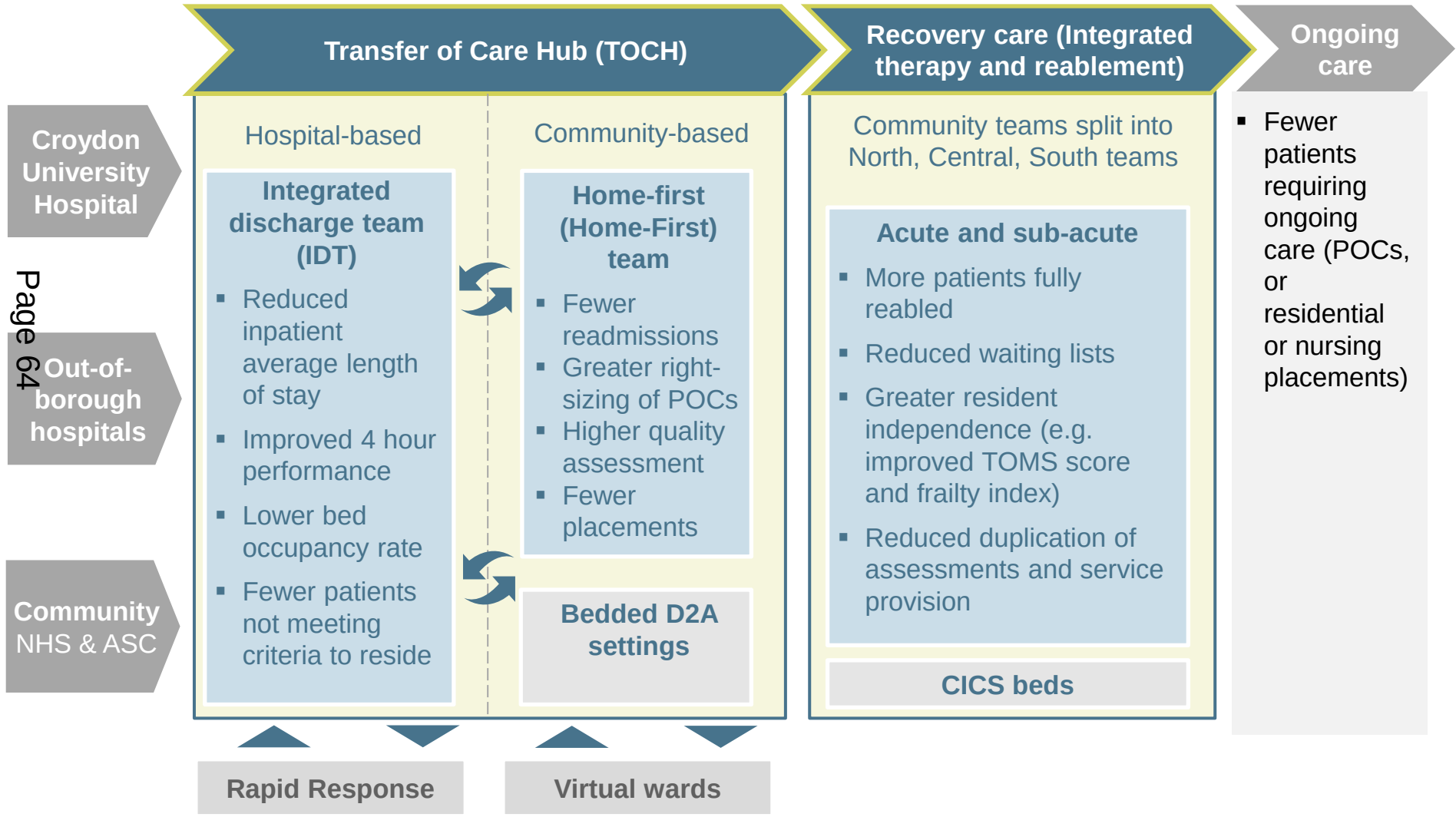
See following pages for detail



Implementing the 'blueprint' will provide benefits across the entire system including reduced unnecessary length of stay in hospital, improved intermediate care outcomes and less ongoing care required

Benefits and KPIs of implementing the blueprint

= Focus of blueprint

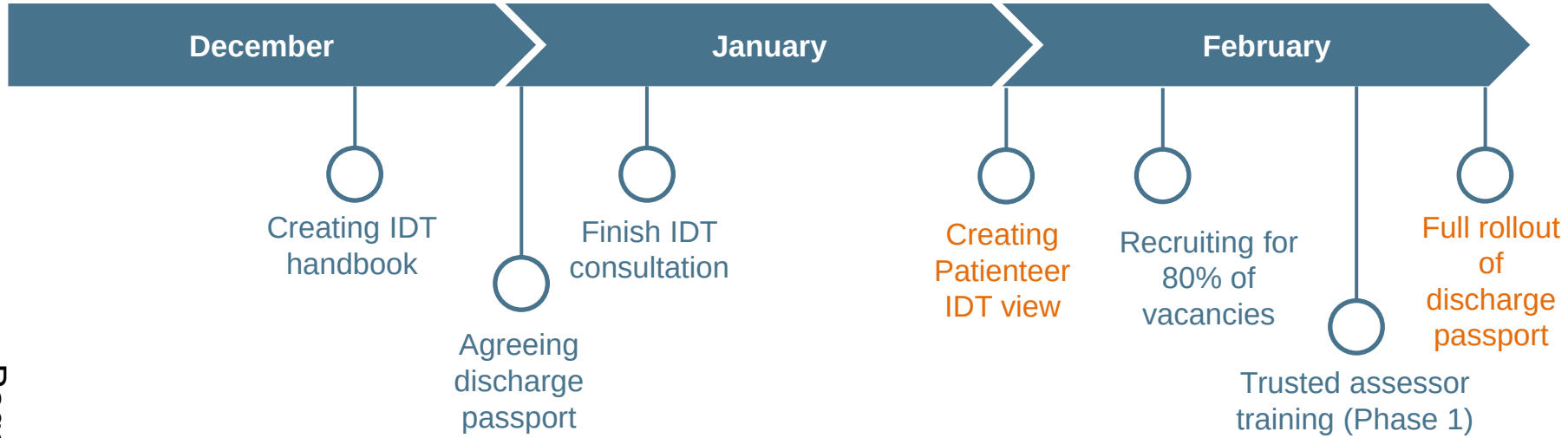


1 IDT and hospital discharge: Key milestones and KPIs

KEY MILESTONES

Non-IT dependent milestones

IT dependent milestones

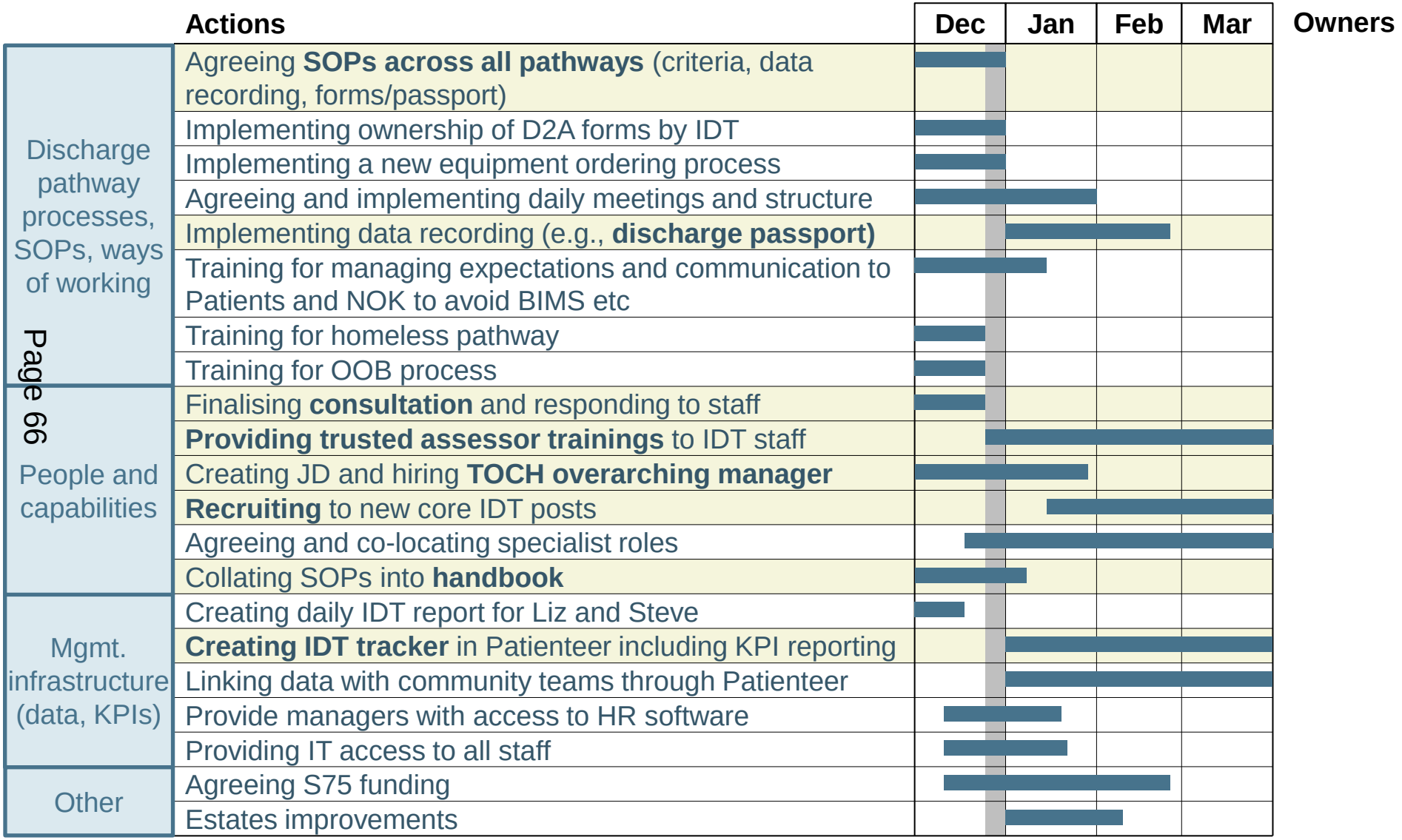


KPIs

Metric	Target
Average length of stay by pathway	~8 days (pre-Covid metric)
Bed occupancy rate	~85% bed occupancy rate (with escalation areas closed during non-winter months)
Proportion of patients in acute beds that meet criteria to reside	90% of patients meeting criteria to reside
# of BIMs completed	
Average time from Part A referral to discharge	

1 IDT and hospital discharge: Action plan

Lead: Liz Wells **Delivery team:** Felicity Hunter, Jennifer Daniel = Priority

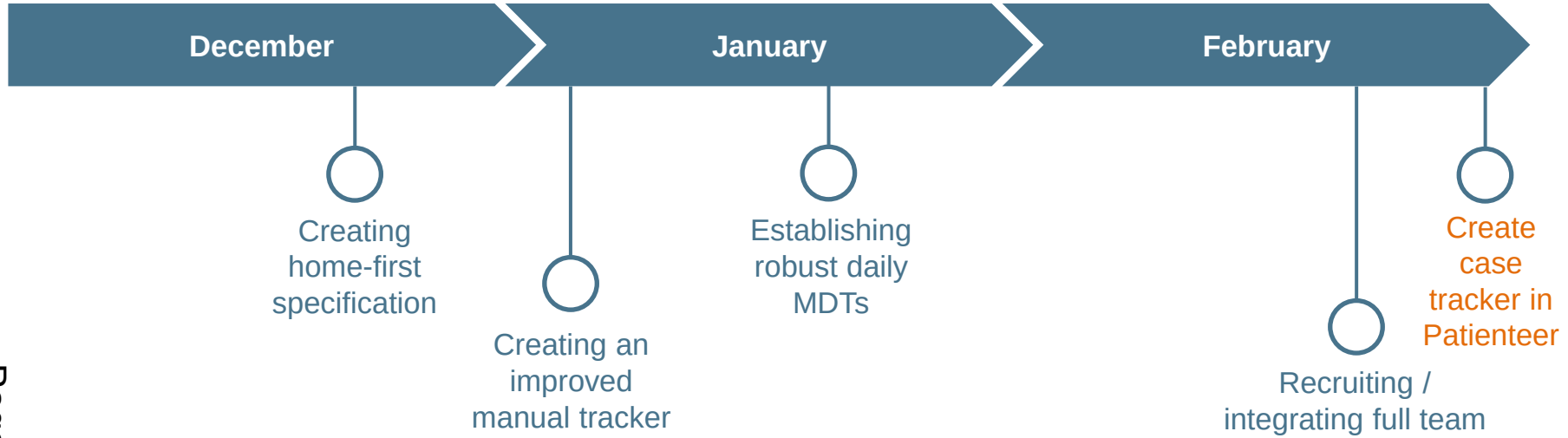


2 Home-first team: Key milestones and KPIs

Non-IT dependent milestones

IT dependent milestones

KEY MILESTONES



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KPIs

Metric	Target
Time from discharge to first assessment (Part B)	
Readmission rate	
% reduction in POC size	
% of residents requiring no ongoing care	
# of hospital placements	

2 Home-first team: Action plan

Lead: Maria Knopp **Delivery team:** Jennifer Daniel, Cynthia Abankwa

= Priority

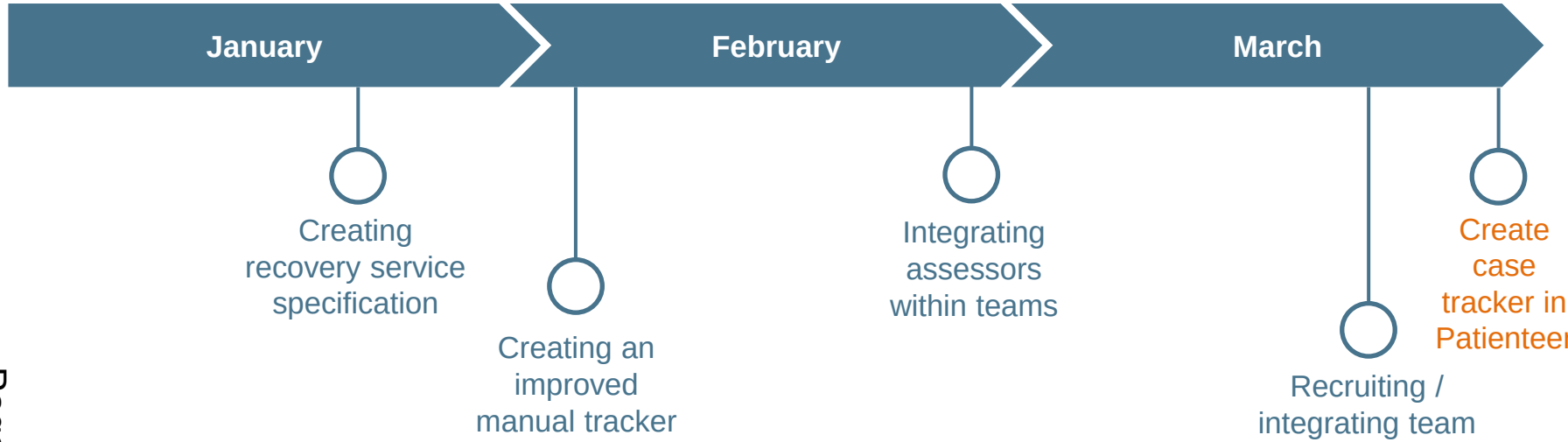
	Actions	Dec	Jan	Feb	Owners
Processes, SOPs, ways of working	Creating updated **assessment forms** (Part B)				
	Creating **specification** for home-first service				
	Establishing daily MDTs				
People and capabilities	Integrating existing **assessor roles** (OOB, Mary's team)				
	Creating JD and hiring **TOCH overarching manager**				
	Agreeing home-first manager				
	Recruiting to new posts and building teams (e.g., therapists, nurses, assessors, manager)				
	Developing training materials				
	Providing trainings to staff (e.g., assessors on holistic assessments)				
	Engaging with care agencies to agree partnership model and commissioning arrangements				
Mgmt. infrastructure	**Agreeing KPIs** and targets				
	Creating improved excel tracker and reporting mechanism				
	Creating case tracker in Patienteer				
Other	Agreeing S75 funding				
	Agree estates for team				

3 Integrated rehab. and reablement: Key milestones and KPIs

Non-IT dependent milestones

IT dependent milestones

KEY MILESTONES



KPIs

Metric	Target
Waiting time to first review	
% reduction in POC size	
% of residents requiring ongoing care	
% of residents fully reabled	
% of residents at home after 90 days	
Change in TOMS / frailty scores	

3 Integrated rehab. and reablement: Action plan

Lead: Maria Knopp **Delivery team:** Jennifer Daniel = Priority

	Deliverables	Dec	Jan	Feb	Mar	Owners
Processes, SOPs, ways of working	Agree referral forms into **therapy/reablement teams**					
	Creating **specification** for integrated teams					
	Establishing daily triage					
	Implementing partnership ways of working with care agencies					
	Agreeing transport arrangements for staff					
People and capabilities	Integrating existing **assessor roles** (OOB, Mary's team)					
	Creating JD and hiring **overarching manager**					
	Agreeing management structure					
	Agreeing reablement options appraisal					
	Recruiting to new posts (e.g., therapists, reablement officers)					
	Developing training materials					
	Providing trainings to staff (e.g., assessors) Develop capability to use TOMS outcome measure					
Mgmt. infrastructure (data, KPIs)	Create a **Patienteer solution** to case manage across therapy and reablement teams					
	Agreeing KPIs and reporting mechanisms					
	Improving commissioning arrangements to create Outcomes based reablement					
Other	Agreeing S75 funding					
	Agree estates					

Agenda

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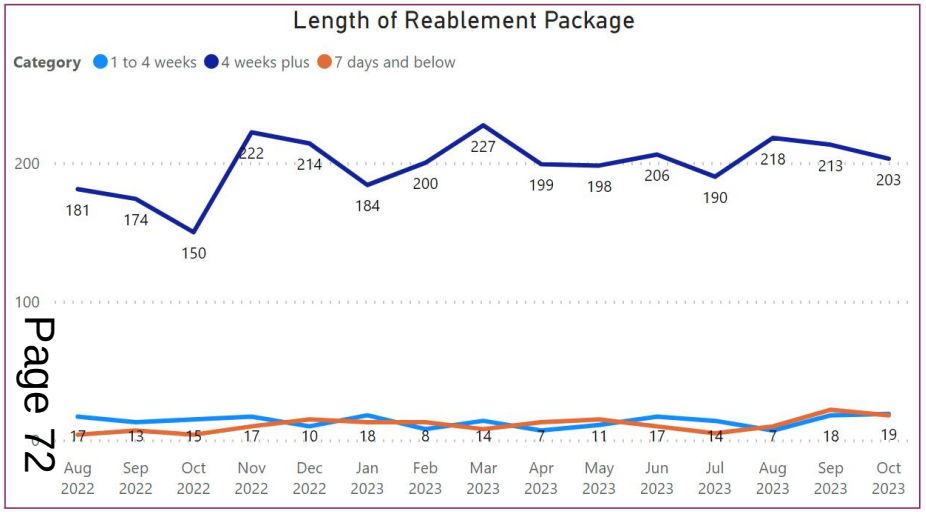
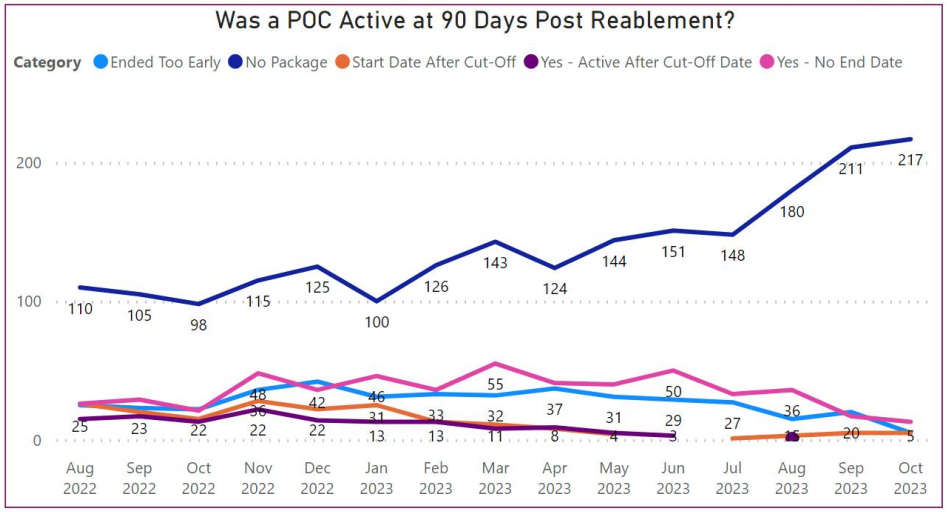
- What's next
- **Appendix**

POC Length & Post Reablement Packages of Care

Oct 2023

One Croydon
Your Health and Care partnership





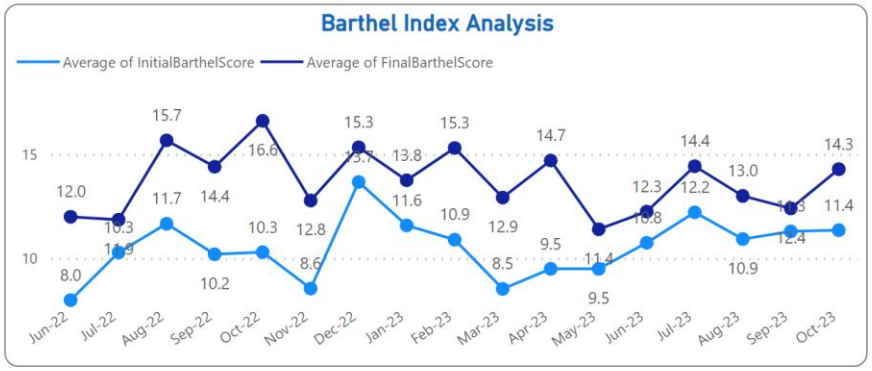
Category	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023
1 to 4 weeks	17	13	15	17	10	18	8	14	7	11	17	14	7	18	19
4 weeks plus	181	174	150	222	214	184	200	227	199	198	206	190	218	213	203
7 days and below	4	7	4	10	15	13	13	8	13	15	10	5	10	22	18
Total	**202**	**194**	**169**	**249**	**239**	**215**	**221**	**249**	**219**	**224**	**233**	**209**	**235**	**253**	**240**

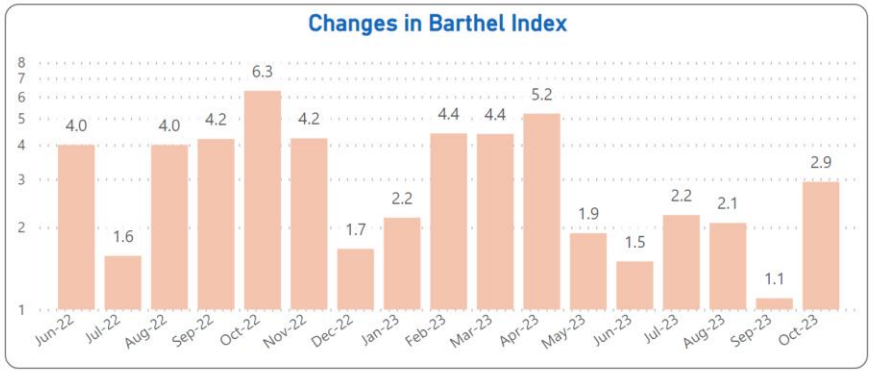
Category	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023
Ended Too Early	25	23	22	36	42	31	33	32	37	31	29	27	15	20	5
No Package	110	105	98	115	125	100	126	143	124	144	151	148	180	211	217
Start Date After Cut-Off	26	20	15	28	22	25	13	11	8	4		1	3	5	5
Yes - Active After Cut-Off Date	15	17	13	22	14	13	13	8	9	5	3		1		
Yes - No End Date	26	29	21	48	36	46	36	55	41	40	50	33	36	17	13
Total	**202**	**194**	**169**	**249**	**239**	**215**	**221**	**249**	**219**	**224**	**233**	**209**	**235**	**253**	**240**

Comments

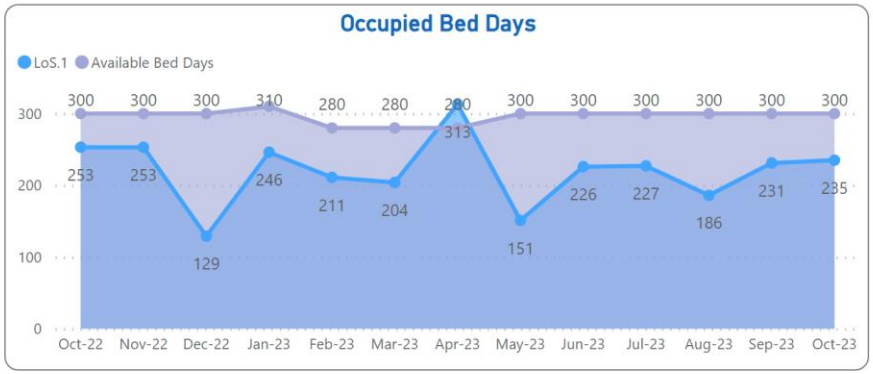
Intermediate Bed

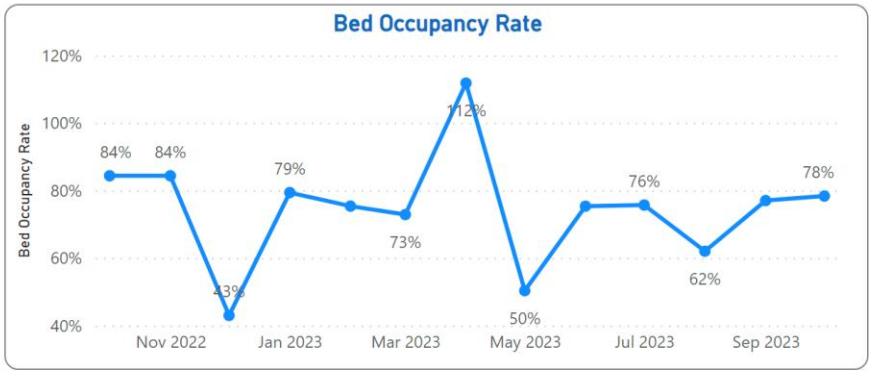
Avg. Initial Score 11.4 Avg. Final Score 14.3 2.9





235 78%





Note: Patient LoS is being used to calculate Occupied Bed Day due to the lack of mid-night occupancy data for intermediate beds. Hence, there is possibility of over counting of occupied bed days where two patients have used a bed on the same day.

Professional | Compassionate | Respectful | Safe

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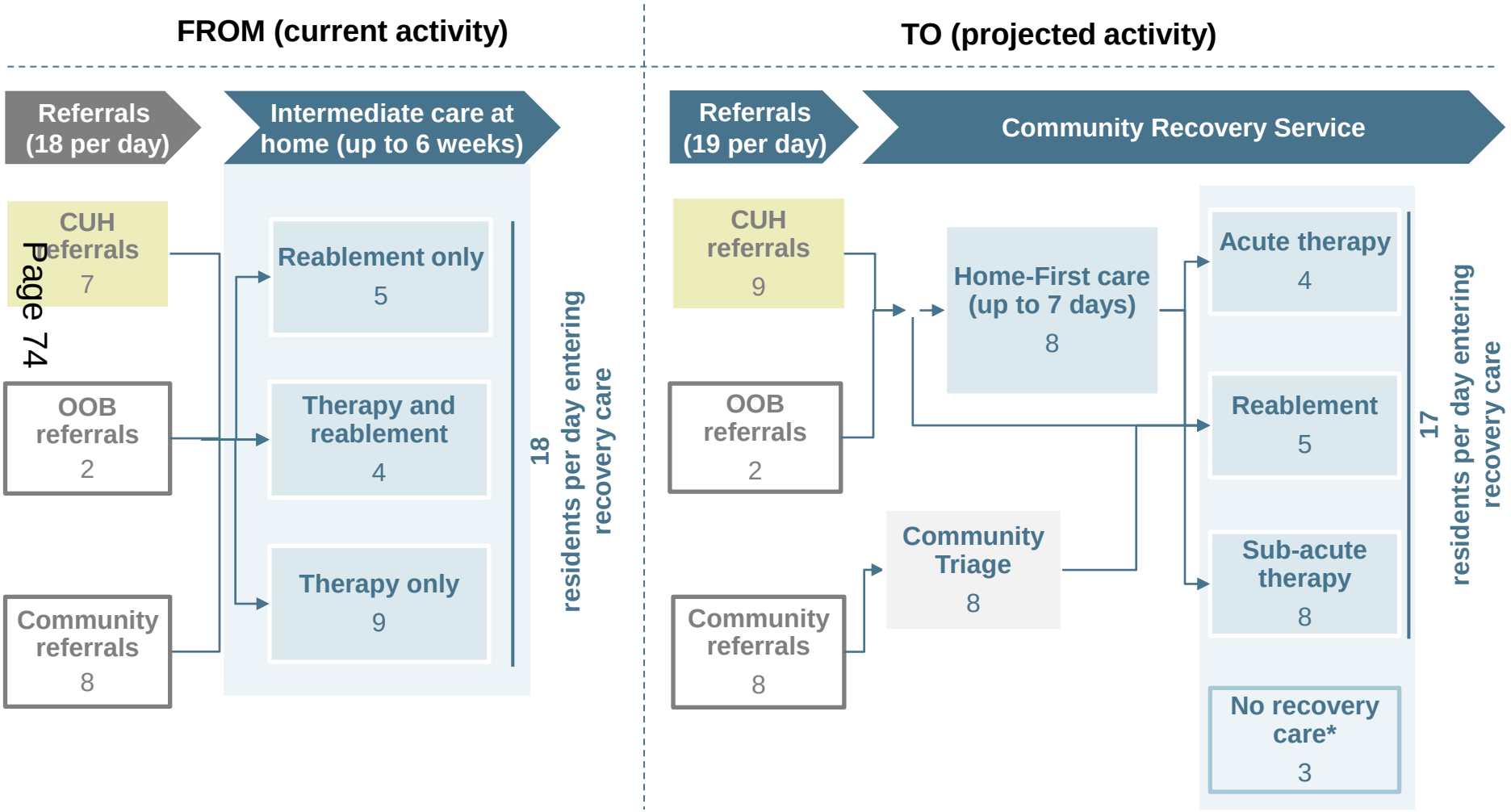
Activity: We predict that despite an increase in referrals, fewer residents will require recovery care (decrease from 18 to 16 each day) due to the Home-First service

Daily number of referrals for intermediate care at home from Croydon residents by source and outcome, #, Aug '22 – Jul'23



Note: Some numbers may not add up due to rounding

***including patients that go straight into ongoing care e.g. no reablement potential

	Key Outcomes	KPIs
	Pathway 1	
	Reduction in waiting lists for community therapy and reablement	• Average waiting time across recovery care services (for urgent within 2 days. Non-urgent within 2 weeks
	Improved outcomes for patients receiving therapy and reablement in the community • Increased independence at home • Reduction in average time spent under the care of the services • Increased proportion of residents being fully reabled / rehabilitated within 6 weeks (50% of people being fully reabled) • Greater increase in Bartel Index and TOMs score	• Number of resident's receiving recovery care at home by referral source (Step up and Step down) • Number of resident's returning to their usual place of residence (link to BCF Metric) • Reablement: 50% of patients fully reabled within 6 weeks • Therapy: 50% of patients not requiring a POC after 6 weeks of referral • Target: 85% of residents achieving their goals post discharge from Intermediate care
	Reduction in readmissions to hospital	• Readmission rate of patients discharged from hospital
	Reduction in avoidable admissions to hospital	• Number or rate of avoidable admission (link to BCF Metric)
	Improved wellbeing of residents (patients and carers)	• Increase in Wellbeing scores • 80% of people achieving their goals (wholly or partially)
	Reduction in siloed working and duplication across community teams to maximise the use of available resources to offer the best possible support to residents	• 90% of residents satisfaction/ FFT • 90% of Staff satisfaction • 100% of resident's and carers that feel involved in the planning of their care
	Preventing or reducing the need for long term packages of care	• Number of new long term residential placements / POCs (link to BCF metric) • Number of long-term nursing placements / POCs (link to BCF metric)
	Pathway 2	
	Retaining the LOS to 2 weeks for all residents	• 90% of residents being discharged within 14 days
	Reducing the waiting times for medically fit residents discharged	• TBC – Hospital to identify residents suitable to pathway 2
	Reducing the number of inappropriate referrals from hospital	• Service should have no greater than 5% inappropriate referrals
	Reducing the number of residents who go into a step-up bed	• 95% of residents fully discharged home
	Measure the quality of care provided to residents include carers	• 95% of residents satisfied with the service
		•
	Pathway 3 reducing the LOS in hospital	• Reduce LOS in hospital by 10% (11 days)

The proposed blueprint will have a number of benefits across hospital and community

	Hospital	Community
Benefits	▪ Improved flow through the hospital ▪ Fewer handovers and duplication of tasks ▪ Fewer discharge delays ▪ Fewer MO patients 'stuck' in hospital ▪ Better discharge experiences for patients ▪ Less deconditioning of patients	▪ Improved assessment quality ▪ Reduced duplication across teams ▪ Easier access to multidisciplinary support for residents ▪ Reduced spend on care agencies
How these benefits will be achieved	▪ Creating an effective IDT ▪ Improved early discharge planning on the wards ▪ Improved information flows between wards, IDT and community teams ▪ Streamlining discharge pathways ▪ Improving joint ways of working	▪ Delivering a new 'Home-First' service ▪ Integrating teams ▪ Developing an integrated 'assessor' JD and providing training where required
KPIs	▪ Average length of stay ▪ Daily number of discharges ▪ Bed occupancy rate	▪ Percentage of people fully reabled ▪ Improvement in Barthel index ▪ Waiting list ▪ Number of patients going into ongoing POC or residential care ▪ Reduced readmission rates

Home-First: Resident feedback

Really pleased to confirm that the Home-First service has worked well for us

Lack of Liaising with family regarding time of care provision. Otherwise, service was really good

I am very happy with the care package provided

Good service, they took good care of me but requires improvement

I have received nice treatment from my carer

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LONDON BOROUGH OF CROYDON

REPORT:	**HEALTH AND WELLBEING BOARD**	
DATE OF DECISION	**WEDNESDAY 24TH JANUARY 2024**	
REPORT TITLE:	**Joint Local Health and Wellbeing Strategy (JLHWS): Healthwatch Croydon Community Engagement Session- Summary Report**	
LEAD OFFICER:	**EDWINA MORRIS, CHAIR, HEALTHWATCH CROYDON edwina.morris@healthwatchcroydon.co.uk 07855 452171 GORDON KAY, MANAGER, HEALTHWATCH CROYDON gordon.kay@healthwatchcroydon.co.uk 07485 393580**	
LEAD MEMBER:	**COUNCILLOR YVETTE HOPLEY, CHAIR OF HEALTH AND WELLBEING BOARD AND COUNCIL MEMBER FOR HEALTH AND ADULT SOCIAL CARE**	
AUTHORITY TO TAKE DECISION:	**Constitution of the London Borough of Croydon - Part 4.L – Terms of Reference Health and Wellbeing Board1.4 To exercise the functions of the Council in preparing a joint health and wellbeing strategy under Section 116A of the Local Government and Public Involvement in Health Act 2007**	
KEY DECISION? [Insert Ref. Number if a Key Decision] ***Guidance**: A Key Decision reference number will be allocated upon submission of a forward plan entry to Democratic Services.*	**No**	REASON: N/A
CONTAINS EXEMPT INFORMATION? ***(* See guidance)***	**NO**	Public

WARDS AFFECTED:	All

1. SUMMARY OF REPORT

1. The Health and Wellbeing Board are keen to ensure that the views of local residents are reflected in the refresh of the local joint health and wellbeing strategy and, as part of this, Healthwatch Croydon conducted a Community Engagement session during the Annual Meeting on 29 November 2023, with the findings and recommendations being taken into account in the production of the formal consultation document. Attendees were invited to consider the draft strategy that Public Health colleagues had produced following their work gathering community insights from local reports produced by Healthwatch Croydon, local VCFS organisations and others, alongside the findings of Joint Strategic Needs Assessment reports. A report outlining the activities and outcomes of this session is included as Appendix A.

2. The Community Engagement session was attended by more than 50 local residents, and addressed three questions, which were:

   (a) What does health and wellbeing mean to you?

   (b) Does the draft vision statement reflect our shared values, collective identity and health and wellbeing ambitions in Croydon and is it easy to understand?

   (c) Are the draft priorities the right ones, are any missing or should any be removed?

3. All the attendees were encouraged to participate in discussions and in putting their thoughts and suggestions on post-it notes which were displayed and have been analysed. These comments have been transcribed into the report (Appendix A), and have been considered when drafting the consultation document, which is also on the agenda for this Board meeting.

4. The key findings and recommendations arising from this Community Engagement session are summarised in a presentation that accompanies this report.

2 RECOMMENDATIONS

For the reasons set out in the report [and the presentation], the Health and Wellbeing Board is recommended:

1. to note the findings and recommendations in the report of the community engagement undertaken by Healthwatch Croydon; and

2. to agree to the inclusion of these findings and recommendations in the draft local joint Health and Wellbeing Strategy refresh consultation document, which is addressed in other reports on this agenda.

3. REASONS FOR RECOMMENDATIONS

3.1. The legislation relevant to the Health and Wellbeing Board's responsibilities for the local joint health and wellbeing strategy refresh is summarised in section 8.2. This includes, in paragraph 8.2.5, the involvement of the Local Healthwatch and local people in the preparation of the strategy. This report, together with Appendix A, sets out the views of local people on the draft vision and priorities, as articulated during the recent community engagement session run by Healthwatch Croydon.

3.2. The community engagement session was organised specifically to provide information from local people that could inform the formal consultation document, which is the subject of another report on this Board's agenda. Members of the Health and Wellbeing Board are invited to consider whether the formal consultation document, as presented to the Board, has appropriately taken into account the findings and recommendations of the community engagement session.

4. BACKGROUND AND DETAILS

4.1. This information is provided in other sections of the report, Appendix A and the presentation.

5. ALTERNATIVE OPTIONS CONSIDERED

5.1. The responsible local authority and its partner integrated care boards need not prepare a new joint local health and wellbeing strategy if, having considered the integrated care strategy, they consider that the existing joint local health and wellbeing strategy is sufficient.

5.2. On this occasion the Health and Wellbeing Board has concluded that the joint local health and wellbeing strategy should be refreshed, and that the views of local people should be taken into account during this process.

6. CONSULTATION

6.1. The Health and Wellbeing Board has taken a partnership approach to refreshing the Joint Local Health and Wellbeing Strategy. This report presents the outcome of the

public engagement process in relation to the draft Strategy, the findings and recommendations of which have been taken into account when drafting the Strategy refresh prior to the formal consultation process.

7.CONTRIBUTION TO COUNCIL PRIORITIES

7.1. Croydon Health and Wellbeing Strategy supports the delivery of a number of key council priorities, including the following outcomes in Mayor's Business Plan (2022-26)

Outcome 5. People can lead healthier and independent lives for longer

Priority 1. Work with partners and the VCFS to promote independence, health and wellbeing and keep vulnerable adults safe.

Priority 2. Work closely with health services and the VCFS to improve resident health and reduce health inequalities.

Priority 3. Foster a sense of community and civic life.

7.2. The Strategy will also have crosscutting links with several other outcomes in the Mayor's Business plan, including:

Outcome 3. Children and young people in Croydon have the chance to thrive, learn and fulfil their potential

Outcome 4. Croydon is a cleaner, safer and healthier place, a borough we are proud to call home.

8.IMPLICATIONS

8.1. FINANCIAL IMPLICATIONS

8.1.1. There are no direct financial implications as a result of this report. Any future financial impact will be fully considered as part of subsequent reports as they arise.

8.1.2. Comments approved by Lesley Shields, Head of Finance for Assistant Chief Executive and Resources on behalf of the Director of Finance. (Date 15/01/2024).

8.2. LEGAL IMPLICATIONS

8.2.1. The establishment, composition and functions of the Health and Wellbeing Board are set out in the Health and Social Care Act 2012, sections 194-196. Section 196(1) provides that the functions of a local authority and its partner integrated care boards under section 116 and 116A of the Local Government and Public Involvement in Health Act 2007 (the 2007 Act) are to be exercised by the Health and Wellbeing Board established by the local authority.

8.2.2. Section 116A of the 2007 Act, provides that where the responsible local authority and each of its partner integrated care boards receive an integrated care strategy, they must prepare a strategy ("a joint local health and wellbeing strategy") setting out how the assessed needs in relation to the responsible local authority's area are to be met by the exercise of functions of:

(a)the responsible local authority,
(b)its partner integrated care boards, or
(c)NHS England.

8.2.3. The responsible local authority and its partner integrated care boards need not prepare a new joint local health and wellbeing strategy if, having considered the integrated care strategy, they consider that the existing joint local health and wellbeing strategy is sufficient.

8.2.4. In preparing a strategy under this section, the responsible local authority and each of its partner integrated care boards must, in particular, consider the extent to which the assessed needs could be met more effectively by the making of arrangements under section 75 of the National Health Service Act 2006 (rather than in any other way). In addition, the responsible local authority and each of its partner integrated care boards must have regard to the integrated care strategy prepared under section 116ZB, of the 2007 Act, the mandate published by the Secretary of State under section 13A of the National Health Service Act 2006, and any guidance issued by the Secretary of State. In this regard the current statutory guidance is the Department of Health guidance "Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies". There is also published non-statutory guidance "Health and Wellbeing Boards- guidance" dated 22 November 2022 which is of relevance.

8.2.5. In preparing a strategy under this section, the responsible local authority and each of its partner integrated care boards must:

(a) involve the Local Healthwatch organisation for the area of the responsible local authority, and
(b) involve the people who live or work in that area.

8.2.6. The responsible local authority must publish each strategy prepared by it under this section.

8.2.7. Paragraph 3.5 of the Statutory Guidance referred to above, provides "Health and wellbeing boards will need to decide for themselves when to update or refresh JSNAs and JHWSs or undertake a fresh process to ensure that they are able to inform local commissioning plans over time. They do not need to be undertaken from scratch every year; however boards will need to assure themselves that their evidence-based priorities are up to date to inform the relevant local commissioning plans. To be transparent and enable wide participation, boards should be clear with their partners and the community what their timing cycles are and when outputs will be published".

8.2.8. The Health and Wellbeing Board continues to be responsible for the development of joint strategic needs assessments under Section 116 of the 2007 Act and joint local health and wellbeing strategies.

8.2.9. Comments approved by Sandra Herbert, the Head of Litigation & Corporate Law on behalf of the Director of Legal Services and Monitoring Officer. (Date 09/01/2024)

8.3. EQUALITIES IMPLICATIONS

8.3.1. The Council has a statutory duty to comply with the provisions set out in the Sec 149 Equality Act 2010. The Council must therefore have due regard to:

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act.

(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it

(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

8.3.2. The Health and Wellbeing Strategy crosses all equality/protected characteristics, since it places improving health and wellbeing and reducing inequalities in these outcomes at its core. The refresh of the strategy will aim to benefit all equality and protected characteristics among Croydon residents.

8.3.3. There are a number of Health and wellbeing challenges which may impact particular characteristics such as instances of mental health illness in males, LGBT+ community, racial trauma in the Global Majority and the over representation of the Global Majority in mental health institutions.

8.3.4. The council is a pilot organisation on the Chief Executive London Councils Tackling Racial Injustice Programme. The programme requires each local authority to understand, acknowledge and support racial trauma as an issue affecting the Global Majority in workplaces.

8.3.5. An equality impact assessment has been carried out in December 2023. The assessment identified positive impacts for all protected characteristics. At the time of the assessment, no negative impacts were identified. This assessment will be revisited prior to finalising the strategy in 2024. Further details about this are provided in another report on this committee agenda.

8.3.6. Comments approved by Denise McCausland the Equalities Programme Manager. (Date 08/01/2024)

9. APPENDICES

9.1 *A Feedback from the Healthwatch Croydon Community Engagement Session for the Joint Local Health and Wellbeing Strategy (2024-2029). 29 November 2023*

Feedback from the Healthwatch Croydon Community Engagement Session for the Joint Local Health and Wellbeing Strategy (2024-2029)

29 November 2023

Final report – January 2024

Background to the session

The Health and Wellbeing Board are currently reviewing Croydon's Local Joint Health and Wellbeing Strategy that will set out our vision, principles, and priority areas to improve the health and wellbeing of our local population in Croydon for the next five years (2024-2029).

Healthwatch Croydon, the local champion for health and social care, offered to use the opportunity of the Annual Meeting to discuss the initial ideas of the strategy to inform the pre-consultation stage.

There was a 45-minute session within the Annual Meeting where participants discussed ideas and placed them on notes under three themes, each had approximately 15 minutes.

Over 50 people attended the event and contributed to discussions.


We help people
technology


VISION STATEMENTS
PRIORITIES

Findings

- Importance of good mental health and link to physical health.
- Independence and self-care are key as well as access to green space.
- Support from services and building a strong relationship between services, patients, and wider community.
- Vision statement could be simpler with less jargon and grounded. It needs to focus on equity and representation.
- Access to services still of more consideration for many.
- Need to show more actions rather than just words.
- A concern about reach and awareness to that it is for all the community.
- Wider aspects around environment and social behaviour need to be considered.

Recommendations

- A significant focus on mental health.
- A focus on supporting independence and self-care.
- Environmental impact of good health including green spaces and places for healthy activities.
- Clearer, simpler, jargon-free vision statement.
- Focus on equity and representation.
- Link to specific actions rather aspirations.
- Consider wider aspects such as housing, employment, environment, and work, which influence health and wellbeing.

Part 1- What does health and wellbeing mean to you?

Key concepts:

- **Health:** The state of complete physical, mental, and social wellbeing, not merely an absence of illness (World Health Organisation)
- **Wellbeing:** the state of being comfortable, healthy, or happy (Oxford English Dictionary)
- Brought together, **good health and wellbeing** enables us to live happy, fulfilling lives and enables us to achieve our potential (Health Foundation). We would like to better understand how our local community define health and wellbeing and what matters the most to them regarding their health and wellbeing.

In the first section, we asked participants to find out about what good health and wellbeing means to them. They were encouraged to have discussions with your participants and then add any ideas to Post-it notes provided and add to the relevant wall.

We asked them to reflect on the following prompts in your discussions:

- What does good health and wellbeing mean to you?
- What are the most important factors that contribute to your overall health and wellbeing?
- What activities or practices make you feel your best physically, mentally, and socially?

Themes

Many focused on the importance of good mental health and the link between that and physical health. Independence was also seen a very important. The social aspect was also considered as significant with a good range of activities to help people structure their time. The importance of green space and a positive physical environment was mentioned by many.

Undoubtably, support from services was still very much needed and the importance of building a strong relationship between services, patients, and the wider community. Respondents also mentioned tackling disparities, prevention, access of healthy food and work and supporting carers as factors important for health and wellbeing.

Good mental health

"Can be about perception or mindset of individual – living with/ despite a condition, or just living well?"

"Simplicity; child-like experiences; little things."

"Meaning… longevity, relevance."

"Wellbeing – what you need to funnel positivity. Activity/Nature/Family/Friends."

"Mental health and physical health are intrinsically linked."

"Health and wellbeing: peace of mind, family, independence."

"Wellbeing – not worrying about health."

"Not having to worry! About money, food, healthcare access, personal safety."

"Quality of life: positive mental outlook, living independently making their own choices."

"A system which needs to be & remain in balance. Psychological, social safety. Walking in nature, yoga."

"Quality of life means being able to function and meet your needs so you can be happy."

Independence

"Being able to live and independent life."

"Choice and control."

"Move around to cook, to know what medication to take."

"Health and wellbeing independence."

"Self care – Doing it for me not just for others."

"Autonomy – control."

"Quality of life: positive mental outlook, living independently making their own choices."

Social

"Wellbeing – social connections are vital. Support health, help spot early warning signs.

"Community- belonging."

"Being part of a community."

"Things that help social connection: being active, purpose, time focus, support."

"Community celebration, for example Diwali, choir, singing."

"Strong community spirit and social connections."

Activities and structure

"Ensuring people are active – maybe have structure to the day." "Wellbeing – what you need to funnel positivity." "Activity/Nature/Family/Friends."

"Older people have good mental health and can access adequate support."

"Wellbeing: walking, community"

"Daily living activities."

"Activities programmes – Walking, swimming."

"Free exercise opportunities for the elderly."

Green space and good physical environment

"Environment; Greenland."

"Clean streets – know your neighbours."

"Access to green spaces."

"A warm home."

"Warm home."

"Good Living Accommodation."

"Peaceful streets and communities free of antisocial behaviour."

"A system which needs to be & remain in balance. Psychological, social safety. Walking in nature, yoga."

"Wellbeing – what you need to funnel positivity. Activity/Nature/Family/Friends."

"Wellbeing – making use of amenities around you – learning, engaging, support."

Support

"Selsdon connect; Local neighbourhood group has lost their council funding and support the local community -Excellent team so helpful."

"Kind and caring health and social care system with people at its heart."

"Accessible GPs and services (equal access for everyone)."

"Information and support when needed."

"Consistent and sustainable support (including statutory support for old people) to remain active and connected outside their homes."

"Older people have good mental health and can access adequate support."

"Bridging relationship between resident and services."

"Family support."

"Caring, compassionate, consistent and continued care – not from different people or carers."

Disparities

"Disparity – lack of time, resources, skills and knowledge."

Prevention

"Crime prevented before happening."

"Having a holistic approach to wellbeing including sexual health and HIV which are often targeted for some but not everyone!!"

Access to healthy diet

"Healthy Diet/ Work."

Carers

"Support for carers (accessible support and awareness of available support)."

"Carers' own wellbeing may be low down the lot – may not make time."

Part 2 - Feedback on Croydon's vision for our health and wellbeing (15 minutes)

In Croydon, we know that improving health and wellbeing and tackling inequalities is everybody's business, and no one individual, group or organisation can rise to this challenge alone.

In this section, we wanted to create a shared vision statement for 2024-2029. This statement will be anchored in our shared values and act as our guiding compass, inspiring and directing our collective efforts towards a future we collectively aspire to achieve in terms of our health and wellbeing.

Using insights from existing community engagement events in the Borough since 2018, local community plans, and workshops with the Health and Wellbeing Board and the Health and Care Board, we have developed the following draft vision statement for 2024-2029.

In this section, we wanted to seek feedback on the below draft vision and understand how it could be improved to better reflect our shared values and health and wellbeing ambitions.

> ***"In Croydon, we envision a future where every resident leads a happy and fulfilling life supported by safe, healthy, and thriving communities. Through working together and focusing on our strengths, we actively tackle inequalities, ensuring our Joint Local Health and Wellbeing Strategy serves as a catalyst for transformative community wellbeing."***

When providing feedback and suggesting areas for improvement, participants were encouraged to reflect on the following:

1. Does the draft vision statement reflect our shared values and collective identity in Croydon?
2. Does it reflect our collective health and wellbeing ambitions?
3. Is it brief and clear? Is it easy to understand?
4. Is the language appropriate?
5. Is there anything that needs to be added or removed from this statement? How could it be improved? Add it to the Post-it notes and place it on the relevant wall.

Themes

There was confusion about the statement suggesting it could be simpler and less corporate without the jargon. Others were concerned about how it relates to the strategy behind it and how it could be delivered bearing in mind the financial challenges. It was clear that equity and representation needed to be reflected more in it, particularly on engaging with populations who do not normally get involved. Despite this being a vision, some were still focused on basic priorities such as access to specific services such as GPs and advocacy, showing that residents still look towards services rather than visions and strategies to support them. This suggests a communications gap that needs to be bridged. Others saw this again as just words, suggesting that the vision needs to be more active, reflecting actions that will be achieved, rather than just aspirations. Others wondered how self-care could be reflected in this.

Hard to understand or confusion about its role

"Joint Health and Wellbeing Strategy" – might be a bit abstract, hard to relate."

"Needs simplifications – does reflect values – general public's wording, too corporate level language. Needs to be resident level language."

"Suggested simpler wording: Our vision is a community where everyone is happy, healthy and has equal access to the support they need."

"Depends on the strategy that's behind it."

"What is your action plan?"

"Catalyst and transformative – bit jargon-y?"

"Need a joined up approach to health and wellbeing?"

"How can the vision go forward with funding cuts?"

Equity and representation

"Just inequality or equity?"

"Social determinants – good housing – income."

"Many residents are home alone with no access to technology. How ought we to contact them to invite them to attend events."

"Young people awareness."

"Vision: Needs to include how to engage with more people to attend wellbeing events."

"New faces – always same faces."

"Vision should focus on people not usually attending."

"Sometimes fail to consider inequalities existing among the groups who support individuals – e.g. lack of resources for the voluntary sector."

Services and information

"Access in getting GP surgeries appointments."

"Awareness of services."

"Health and social care is responsive to individual needs."

"I agree with the older population support so they can have happier healthier independent lives as long as possible."

"Advocacy for accurate information."

Actions

"Action speaks louder that words."

"Talk less more action."

"Dietary; exercise; socialising; not isolation."

"Build trust."

"Important that it reflects the fact that it is going to be realised and for the community. This will increase commitment."

"Stop meetings about.. instead take action."

Self care

"Access to up to date & helpful info on how I can manage by own health."

"De-learning habits."

Part 3: Are these the right priorities?

As we don't have unlimited resources, we need to focus our efforts on areas that would make the most difference in our lives. In this last section of engagement, we would like to collect views and feedback on what areas the Joint Local Health and Wellbeing Strategy should focus on to make the greatest positive impact on the health and wellbeing and existing inequalities in Croydon.

The following draft priority areas of focus were identified based on available data, evidence, and insights; feedback from stakeholders in health and social care and our local Voluntary and Community Sector; local community plans of six community partnerships and feedback from community engagement events in Croydon since 2018 (see appendix A).

In this section we asked for feedback on:

1. Do we have the right priorities in place?
2. Are there any key areas missing or are there any areas that need to be removed?

Themes

There was a distinct emphasis on ensuring that services were a priority from GP appointments to talking therapies and support for older people and healthy living. Another key priority was around reach, ensuring that all aspects of the community, young and old, healthy, and unwell, were part of the conversation and contributed to making this happen.

There was also a consideration of raising awareness of this strategy as well as some conditions not always considered in plans. There was sense that making sure that tackling inequalities was a key priority and enabling people to have a good quality of life. Some focused on wider aspects such as apprenticeships, fly-tipping and antisocial behaviour. Some also saw the limits of the strategy and the need to ground it. Only one response stated it worked well as it is.

Services

"GP Appointments."

"Access to talking therapies."

"Referrals to scan etc."

"Physiotherapy and Occupational services."

"Support Age UK who support older people possible – exercise, socialise, information."

"Frequent evaluation of services."

"Available activities and resources across the borough. For example, healthy options in Purley."

Reach

"Reaching residents in care homes / activities."

"Involve all stakeholders (voluntary. Private sector etc)."

"Aligned partnerships working for explicitly – coproduced, co – ownership with the community. Empowering community (and organisations) to decide and collaborate."

"Working at grassroots level. Letting communities lead (better understanding of the issues and better connection and engagement with their communities)."

"Bridging the Gap (communication) Parents, Children, Young People."

Awareness

"Awareness building."

"Awareness of hereditary diseases e.g. Sickle Cell Thalassaemia etc."

"Lupus awareness."

"Sickle cell awareness."

Addressing inequalities/ inequities

"Maybe stuff missing in terms of actively addressing inequalities – for reaching seldom heard, isolated."

"Getting equitable service? for money spent."

"Ensure everyone understands the priorities."

Quality of life

"Good Health to enjoy life."

"Mental health," **"Age with dignity."**

"Simplicity of life."

Prevention

“Priorities – High prevention.”

“Increase work with parents/ families. Prevention approach for unwanted pregnancies & crime rates.”

Wider aspects

“Apprenticeships to meet staff shortages.”

“Tacking anti -social fly tipping more trees lined roads.”

“Allotments; Grow fruit in veg more access. Community projects- Plant a tree-lined roads.”

“Healthy environments.”

Limits

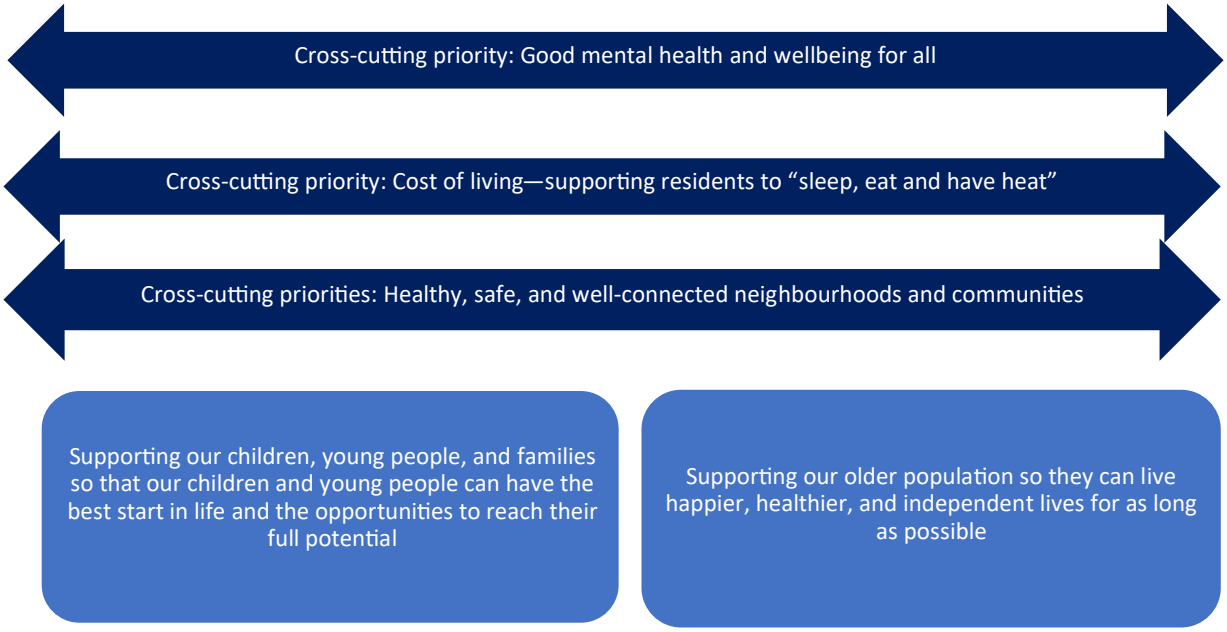
“Transformative – What does this mean? Vision sounds lovely but realistically with financial issues what is possible?”

“What is the action plan to achieve this?”

Works well as it is

“Similar to Age UK priorities works well.”

Appendix A: Draft priority areas of focus:



Guiding principles (these principles will guide our actions towards these priorities):

For Reference: Priority areas for 2024-2029

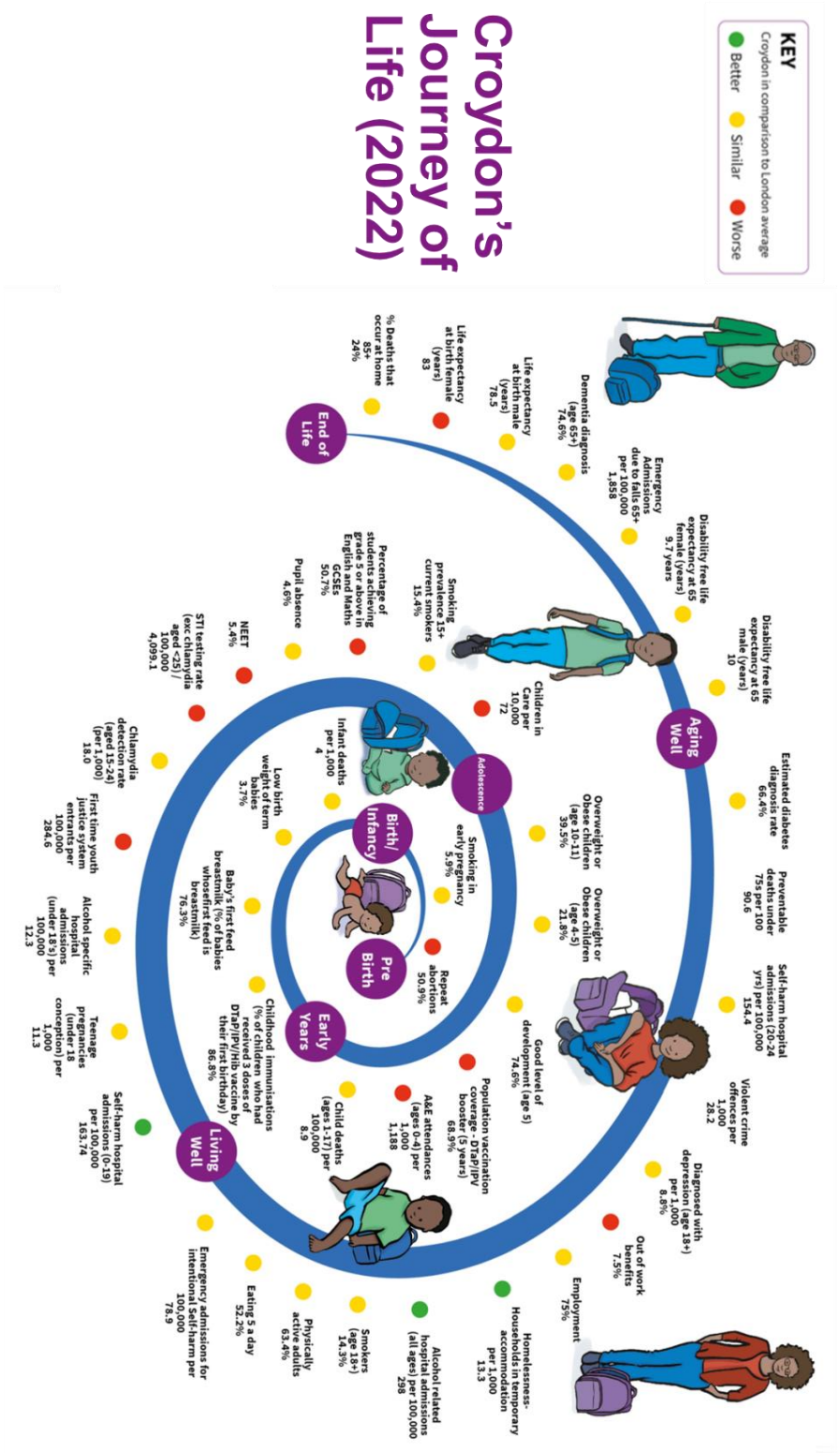
Croydon has a diverse, vibrant, and growing population. With a population of 390,719, it is now the **largest borough** in London.

- Croydon has the **largest population of children and young people** in London, where one in four of our people are under 18 years old.
- Croydon also has a **relatively high proportion of older people**: around one in seven people in Croydon are over 65 years old.
- Our communities come from **diverse backgrounds**: around 52% of our population are from Black, Asian and Minority Ethnic Groups, and around 5 in 6 (84%) of people speak English as their main language. After English South Asian (4.8%) languages, Other European (EU) language (4.7%), Portuguese (1.3%), Spanish (1.0%) and East Asian (0.8%) are the most common main languages.
- The latest data shows that between 2018 and 2020, the average life expectancy for men in Croydon was **79.8 years**, while it was **84.7 years** for women. However, during this time, men from the most deprived areas in Croydon were expected to live **just under 5.8 fewer years** than men from the least-deprived areas. The gap in life expectancy between the poorest and richest areas in women was **6.2 years**.

Our health is more than just and absence of illness and that it is a state of complete physical, mental, and social wellbeing. Our health and wellbeing are shaped by many factors. Existing research suggests that while healthcare itself contributes to between 15 and 25% of our health and wellbeing, wider factors such as the quality of our homes, our access to education and good quality jobs and working conditions, the strengths of our social connections and quality of neighbourhoods, and whether we experience poverty and discrimination play a greater role.

To create safe, healthy, and thriving communities, we need these right building blocks in place. In Croydon, we believe in the power of partnership and collaboration to do this. To make a meaningful difference in our health and wellbeing, we need to work together and take collective action across our life course to promote good health and wellbeing and prevent ill health.

While we are bold in our ambitions, we know that we have many challenges to consider for improving our health and wellbeing and tackling health inequalities in Croydon. Our Joint Strategic Needs Assessment summarises these key challenges and compares the health and wellbeing of our residents to London and England. The figure presenting Croydon's Journey of Life on the next page shows how key health and wellbeing outcomes across our life course in Croydon compare with data from London.



Adapted from ADPHR 2022. Available from https://www.croydon.gov.uk/sites/default/files/2022-12/public-health-report-2022-full-report.pdf *NEET: Not in Education, Employment and Training, Life expectancy at birth for males and females represent 201

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LONDON BOROUGH OF CROYDON

REPORT:	**Health and Wellbeing Board**	
DATE OF DECISION	**24 January 2024**	
REPORT TITLE:	**Croydon Joint Local Health and Wellbeing Strategy Refresh: progress update and next steps**	
CORPORATE DIRECTOR / DIRECTOR:	**Rachel Flowers, Director of Public Health**	
LEAD OFFICER:	**Dr Jack Bedeman, Consultant in Public Health** **Email: jack.bedeman@croydon.gov.uk** **Telephone: 22616**	
LEAD MEMBER:	**Councillor Yvette Hopley**	
DECISION TAKER:	**Health and Wellbeing Board**	
AUTHORITY TO TAKE DECISION:	**Constitution of the London Borough of Croydon - Part 4.L It is a function of the Health and Wellbeing board to encourage, for the purpose of advancing the health and wellbeing of people in Croydon, persons who arrange for the provision of any health or social care services in Croydon.**	
KEY DECISION? [Insert Ref. Number if a Key Decision] ***Guidance**: A Key Decision reference number will be allocated upon submission of a forward plan entry to Democratic Services.*	**No**	**N/A**
CONTAINS EXEMPT INFORMATION? ***(* See guidance)***	**No**	**Public**
WARDS AFFECTED:		**All**

1 SUMMARY OF REPORT

1.1 The Health and Wellbeing Board have agreed to refresh the current strategy in March 2023.

1.2 This report provides updates to the refresh, summarising insights from the joint Health and Wellbeing Board and Health and Care Board workshop, presenting the consultation pack and next steps.

2 RECOMMENDATIONS

The Health and Wellbeing Board is recommended to:

2.1 To note progress with the Joint Local Health and Wellbeing Strategy (JLHWS) Refresh, including insights from the joint Health and Wellbeing Board and Health and Care Board workshop and the draft JLHWS for consultation.

2.2 Agree the next steps in collating and responding to the feedback from the consultation and finalising the strategy.

3 REASONS FOR RECOMMENDATIONS

3.1 There is a statutory requirement for the Health and Wellbeing Board to produce a 'Joint Local Health and Wellbeing Strategy' (JLHWS) to improve the health and wellbeing of the local community and reduce inequalities across the life course.

3.2 With the implementation of the Health and Care Act 2022, Health and Wellbeing Boards continue to be responsible for the development of the JLHWS. However, the Act notes that the Boards 'must now have regard to the integrated care strategy when preparing their joint local health and wellbeing strategies in addition to having regard to the NHS Mandate.'[1]

3.3 The Health and Wellbeing Board is currently refreshing the JLHWS for 2024-2029. This process includes a formal consultation period scheduled for 15 January-19 February 2024.

4 BACKGROUND AND DETAILS

4.1 Croydon Health and Wellbeing Board (HWB) has a statutory duty to develop the JLHWS. This strategy aims to improve the health and wellbeing of people the local community and reduce inequalities across the life course.

4.2 The HWB agreed to review and refresh the JLHWS in March 2023 and received progress updates in October 2023.

[1] More information is available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1099832/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-2013.pdf.

4.3 In November 2023, the HWB and the Health and Care Board held a joint workshop to review and revise the vision, guiding principles and priority areas of focus for 2024-2029. This was informed by:

- Data and evidence from the Joint Strategic Needs Assessment,
- Alignment with key strategies including the Mayor's Business Plan and the South West London Integrated Care Partnership Strategy,
- Input from community events in the Borough and the Community Plans of six Local Community Partnerships.
- How much positive impact each priority can make on individuals and communities.

A summary of this workshop is included in Appendix I.

4.4 Insights from the joint workshop were used to develop the draft vision, guiding principles and priority areas of focus for the revised strategy. These were then shared and discussed at the Healthwatch Community Engagement event in November 2023. Insights from the Healthwatch Community Engagement event are presented in a separate Board report.

4.5 A consultation pack was developed based on feedback and insights from the above two events. Collaborating with the council's Consultation team and Communications and Engagement colleagues, a consultation was launched on 15 January 2024. This consultation will run until 18 February 2024. For the draft vision, guiding principles and priority areas of focus for 2024-2029, please see supporting material titled 'Consultation pack-draft JLHWS 2024-2029-V1.0.pdf.'

4.6 The following table shows indicative timelines for the remaining phases for the review and refresh.

Task	Description	Date
Public consultation period	Formal public consultation	15 January-19 February 2024
Final draft ready for review and agreement	Final draft prepared incorporating feedback from the public consultation.	March 2024
Review and agreement by HWB Board	Final draft reviewed and approved by the Health and Wellbeing Board	March-April 2024
Review and agreement by full Council	Strategy approved by Full Council.	May 2024
Publication of updated Strategy	New Strategy published.	Expected June 2024

5 ALTERNATIVE OPTIONS CONSIDERED

5.1 The responsible local authority and its partner integrated care boards need not prepare a new joint local health and wellbeing strategy if, having considered the integrated care

strategy, they consider that the existing joint local health and wellbeing strategy is sufficient.

6 CONSULTATION

6.1 The Health and Wellbeing Board has taken a partnership approach to refreshing the Joint Local Health and Wellbeing Strategy. This report presents the public consultation process for the draft Strategy.

7. CONTRIBUTION TO COUNCIL PRIORITIES

7.1 Croydon Health and Wellbeing Strategy supports the delivery of a number of key council priorities, including the following outcomes in Mayor's Business Plan (2022-26)

- Outcome 5. People can lead healthier and independent lives for longer
  - Priority 1. Work with partners and the VCFS to promote independence, health and wellbeing and keep vulnerable adults safe.
  - Priority 2. Work closely with health services and the VCFS to improve resident health and reduce health inequalities.
  - Priority 3. Foster a sense of community and civic life.

7.2 The Strategy will also have crosscutting links with several other outcomes in the Mayor's Business plan, including:

- Outcome 3. Children and young people in Croydon have the chance to thrive, learn and fulfil their potential
- Outcome 4. Croydon is a cleaner, safer and healthier place, a borough we are proud to call home.

8. IMPLICATIONS

8.1 FINANCIAL IMPLICATIONS

8.1.1 There are no direct financial implications as a result of this report. Any future financial impact will be fully considered as part of subsequent reports as they arise.

Approved by: TBC

8.2 LEGAL IMPLICATIONS

8.2.1 The establishment, composition and functions of the Health and Wellbeing Board are set out in the Health and Social Care Act 2012, sections 194-196. Section 196(1) provides that the functions of a local authority and its partner integrated care boards under section 116 and 116A of the Local Government and Public Involvement in Health Act 2007 (the 2007 Act) are to be exercised by the Health and Wellbeing Board established by the local authority.

8.2.2 Section 116A of the 2007 Act, provides that where the responsible local authority and each of its partner integrated care boards receive an integrated care strategy,

they must prepare a strategy ("a joint local health and wellbeing strategy") setting out how the assessed needs in relation to the responsible local authority's area are to be met by the exercise of
functions of—
(a)the responsible local authority,
(b)its partner integrated care boards, or
(c)NHS England.

8.2.3 The responsible local authority and its partner integrated care boards need not prepare a new joint local health and wellbeing strategy if, having considered the integrated care strategy, they consider that the existing joint local health and wellbeing strategy is sufficient.

8.2.4 In preparing a strategy under this section, the responsible local authority and each of its partner integrated care boards must, in particular, consider the extent to which the assessed needs could be met more effectively by the making of arrangements under section 75 of the National Health Service Act 2006 (rather than in any other way). In addition, the responsible local authority and each of its partner integrated care boards must have regard to the integrated care strategy prepared under section 116ZB, of the 2007 Act, the mandate published by the Secretary of State under section 13A of the National Health Service Act 2006, and any guidance issued by the Secretary of State. In this regard the current statutory guidance is the Department of Health guidance "Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies". There is also published non-statutory guidance "Health and Wellbeing Boards- guidance" dated 22 November 2022 which is of relevance.

8.2.5 In preparing a strategy under this section, the responsible local authority and each of its partner integrated care boards must—(a)involve the Local Healthwatch organisation for the area of the responsible local authority, and (b)involve the people who live or work in that area.

8.2.6 The responsible local authority must publish each strategy prepared by it under this section.

8.2.7 The Health and Wellbeing Board continues to be responsible for the development of joint strategic needs assessments under Section 116 of the 2007 Act and joint local health and wellbeing strategies. However, the Local Health and Wellbeing Strategy is part of the Policy Framework under Article 4 of the Council's constitution, and therefore the approval process is as set out in the Budget and Policy Framework Procedure Rules, and the function of approving the Strategy is a matter reserved to Full Council.

Approved by: TBC

8.3 EQUALITIES IMPLICATIONS

8.3.1 The Council has a statutory duty to comply with the provisions set out in the Sec 149 Equality Act 2010. The Council must therefore have due regard to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act.

- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

8.3.2 The Health and Wellbeing Strategy crosses all equality/protected characteristics, since it places improving health and wellbeing and reducing inequalities in these outcomes at its core. The refresh of the strategy will aim to benefit all equality and protected characteristics among Croydon residents.

8.3.3 There are a number of Health and wellbeing challenges which may impact particular characteristics such as instances of mental health illness in males, LGBT+ community, racial trauma in the Global Majority and the over representation of the Global Majority in mental health institutions.

8.3.4 The council is a pilot organisation on the Chief Executive London Councils Tackling Racial Injustice Programme. The programme requires each local authority to understand, acknowledge and support racial trauma as an issue affecting the Global Majority in workplaces.

8.3.5 An equality impact assessment has been carried out in December 2023. The assessment identified positive impacts for all protected characteristics. At the time of the assessment, no negative impacts were identified. This assessment will be revisited prior to finalising the strategy in 2024. Please see Appendix 3 titled **'Equality analysis form-Draft JLHWS-V1.0'** for details.

Approved by: TBC

9. APPENDICES

Appendix I. Summary of joint Health and Wellbeing Board and Health and Care Board workshop

Appendix 2a. Consultation pack-draft JLHWS 2024-2029-V0.3.pdf

Appendix 2b. JSNA Summary-November 2023.pdf.

Appendix 3. Equality analysis form-Draft JLHWS-V1.0.docx

10. REPORT AUTHORS

1. Dr Shifa Sarica, Public Health Principal

2. Dr Jack Bedeman, Consultant in Public Health

Refreshing Croydon's Joint Local Health and Wellbeing Strategy for 2024-2029: Health and Wellbeing Board and Health and Care Board Joint Workshop

A summary report

Contents

1. Introduction and overview

As part of the Review and Refresh of Croydon's Joint Local Health and Wellbeing Strategy for 2024-2029, Croydon's Health and Wellbeing Board and the Health and Care Board held a joint workshop on 9th November 2023. The workshop focussed on refreshing the vision, principles and priority areas of focus for 2024-2029.

Discussions were informed by insights from Croydon's Joint Strategic Needs Assessment; evolving local, regional and national strategies, insights from community engagement events and local community partnerships, and the outcomes of a previous Health and Wellbeing Board development workshop conducted in partnership with the Local Government Association in June 2023.

This report first summarises the key insights from this strategic workshop and then proposes a draft vision, principles and priority areas based on the key discussions held during the workshop. In conjunction with Healthwatch Croydon, a public engagement workshop is scheduled for 29th November to seek feedback on these prior to the planned public consultation in January 2024.

2. Agenda and attendees

The workshop was open to all Health and Wellbeing Board and Health and Care Board members. A total of 25 people attended the workshop. The agenda and a list of attendees is found in Appendix I.

3. Reflections on the vision

The vision for the Joint Local Health and Wellbeing Strategy sets the Health and Wellbeing Board's long-term aspirations regarding Croydon's health and wellbeing. Anchored in shared values across the partnership, this statement acts as a compass, guiding collective efforts across the Borough.

In the first section of the workshop, attendees reviewed the vision of the current strategy (2019-2023)[1] and discussed how this could be revised for 2024-2029. When reviewing the current strategy, the participants reflected on the following areas:

- Initial thoughts and impressions of the current vision statement
- Whether the current statement is clear and easily understood by all stakeholders
- Whether it is necessary to update the vision to ensure it remains relevant, impactful and inspiring for all.

Overall, participants felt that the current vision statement (2019-2023) broadly covered health and wellbeing aspirations in Croydon. However, there was a general agreement that the vision needed to be revised for 2024-2029.

[1] The vision of the current strategy (2019-2023) is as follows: "Croydon will be a healthy and caring borough where good health is the default not the exception and those that experience the worst health improve their health the fastest."

Feedback highlighted several key considerations for revision:

- **Clarity and accessibility of language:** Participants felt a clear and accessible vision statement was key for the success of the refreshed strategy, noting that having a more concise and specific vision statement would help. Participants felt that the revised vision should be clear and use plain language that is easily understood by all stakeholders, including those withing the health and care system, Voluntary, Community and Faith Sector and our communities.
- **Succinct and personal language:** Overall, participants felt that the language of the vision should be revised to be succinct. The revised vision should use non-management language and incorporate personal pronouns for increased relatability.
- **Strengths-based, motivational and developed with the local people**: Some suggested that the revised vision should be framed in a strengths-based and motivational manner, aligning with the unique needs and strengths of Croydon's residents. Participants highlighted the importance of developing the vision based on what our communities have already told us what they would like to achieve, for example through local community plans. The importance of checking the vision with local communities was also emphasised.
- **Accountability and actionability:** Feedback emphasised the need for a vision that is not only aspirational but also actionable, holding stakeholders accountable for its realisation.
- **Emphasising partnership working for good health and wellbeing and highlighting a focus on inequalities:** Participants discussed that the revised vision should be grounded in a commitment to *working together* to achieve good health and wellbeing and to reduce health inequalities. Suggestions included stating how achieving the vision will positively impact the lives of individuals and communities.
- **Inclusivity and alignment**: Lastly, suggestions were made to ensure the revised vision reflected the diversity and unique needs of Croydon’s population, with a call for a more inclusive and strengths-based approach. Additionally, participants stressed the importance of aligning the vision with broader initiatives and partnerships in the area. This was seen as a useful way to positioning the vision as a driving force for other key strategies, ensuring a strong alignment with place- and system-level initiatives.

4. Reflections on guiding principles

The vision of the Joint Local Health and Wellbeing Strategy is underpinned by principles that guide how the Health and Wellbeing Board works with partners across Croydon and South West London, including the implementation of the Joint Local

Health and Wellbeing Strategy. In the second section of the workshop, participants reviewed the guiding principles included in the current strategy (2019-2023).[2]

Overall, participants felt that the current principles still hold and provide a good starting point for the refreshed strategy for 2024-2029. However, there was a general agreement that existing principles needed to be revised and additional ones need to be added to reflect the changes in Croydon's health and wellbeing landscape over the past five years and to ensure that the Health and Wellbeing Board could achieve its long-term vision.

Below is specific feedback on each priority, including priorities suggested for addition.

Current principals:

1. **Reducing inequalities:** Participants agreed that reducing inequalities should remain as a core principle for 2024-2029. Several participants suggested that this principle needs to be further defined to ensure that inequalities 'in what' is considered, including racial and gender inequalities.
2. **Focusing on prevention:** There was a general agreement that this principle should continue to underpin the vision for 2024-2029. However, suggestions were made to revise the wording to make the definition of 'prevention' clear (for example, to support people to stay well and healthy and prevent ill health) and to ensure there is a clear focus on prevention across the life course.
3. **Increased integration:** Integration was also seen as a key principle for 2024-2029. However, several participants highlighted that this principle should be revised to highlight the importance of aligned partnership instead, focusing on aligned and effective partnership working between health and care services and local communities, including the Voluntary, Community and Faith Sector.

Suggestions for additional principles:

4. **Co-production and co-design with communities:** participants highlighted the importance of co-producing and co-designing health and wellbeing strategies and initiatives with communities. Examples of good practice were shared, including Community Planning Partnerships and local Community Plans.
5. **Evidence-based approach (including oversight and monitoring):** participants highlighted the importance of evidence-based decision making in ensuring effective and efficient use of resources and evidencing impact.

5. Reflections on priority areas of focus

The final session of the workshop focused on revising priority areas of focus for 2024-2029. This session built on insights from the Health and Wellbeing Board

[2] The current Health and Wellbeing Strategy (2019-2023) has three guiding principles: Reducing inequalities, Focusing on prevention, Increased integration.

Development workshop held earlier in June 2023. In this previous workshop, members had affirmed the relevance of the current priorities (2019-2023). However, members had agreed that having fewer and more specific priorities for 2024-2029 would enable effective action planning, delivery and monitoring of outcomes, ensuring maximum impact.

To guide the identification of strategic priorities for 2024-2029, participants were asked to work in groups to undertake a prioritisation exercise. In this group exercise, participants were asked to review the priorities in the current strategy (2019-2023),[3] to identify priorities for addition or removal, and where applicable, to suggest revise wording to enhance clarity or effectiveness for 2024-2029.

Participants were asked to consider the following when discussing priority areas:

- Alignment with data and evidence (Joint Strategic Needs Assessment)
- Alignment with Mayor's Business Plan and South West London Integrated Care Partnership Strategy
- Alignment with feedback from community engagement events in the Borough and Community Plans of six Local Community Partnerships.
- Potential for positive impact on individuals and communities

The feedback received from the groups regarding the strategic priorities for 2024-2029 indicated general agreement on retaining several existing priorities while refining their focus:

- "Priority 1. A better start" in life garnered support across tables with suggestions to include various life stages and emphasise education and employment opportunities.
- Priority 3. Housing and the environment enable all people of Croydon to be healthy: while participants generally agreed to retain this priority, suggestions were made to broaden this priority and include 'safety aspect'. Some also suggested that this priority could be expanded to include issues around cost-of-living considerations and allow residents to "eat, sleep and have heat."
- Priority 4. Mental wellbeing and good mental health as a driver of health: There was a general agreement that mental health and wellbeing are now seen as a driver of health in the borough and the updated strategy should be bolder in this priority. Suggestions were made to revise the wording on this priority to focus on support and incorporate aspects of physical health.

[3] The priority areas in the current strategy (2019-2023) include:
Priority 1. A better start in life.
Priority 2. Strong, engaged, inclusive and well-connected communities.
Priority 3. Housing and the environment enable all people of Croydon to be healthy.
Priority 4. Mental wellbeing and good mental health are seen as a driver of health.
Priority 5. A strong local economy with quality local jobs.
Priority 6. Get more people more active, more often.
Priority 7. A stronger focus on prevention
Priority 8. The right people, in the right place, at the right time.

There was a general agreement that the following priorities in the current strategy (2019-2023) could work as enablers or guiding principles for the revised strategy for 2024-2029:

- Priority 2. Strong, Engaged, Inclusive, and Well-Connected Communities
- Priority 7. A stronger focus on prevention
- Priority 8. The right people, in the right place, at the right time

Lastly, the following priorities received mixed feedback:

- Priority 5. A strong local economy with quality local jobs: while one group suggested that this priority is retained for 2024-2029, other groups placed a higher priority on other areas for 2024-2029.
- Priority 6. Get more people more active, more often: Some participants suggested that this could be retained as a priority, while others believed this priority could be incorporated into other priorities, such as “Priority 4. Mental wellbeing and good mental health are seen as a driver of health” or “Priority 7. A stronger focus on prevention”

Participants also made suggestions for new priority areas emphasising individual and community empowerment to enable people to live safe, healthy and independent lives for as long as possible as well as addressing cost of living and equitable access to health and care services. Ensuring evidence-based approaches, including evidence-based commissioning and implementing robust monitoring mechanisms were also highlighted.

6. Proposed draft vision, guiding principles and priority areas of focus for 2024-2029

Based on the findings of this workshop, this section provides a proposed draft vision statement, guiding principles and priority areas of focus for 2024-2029 that could be used for further consultation.

Please note that these are not intended to be final, and the final strategy will be informed by further engagement events. A community engagement session is planned in collaboration with Healthwatch Croydon to seek feedback on these suggested draft vision statement, guiding principles and priority areas of focus. Feedback from this session will be incorporated into the consultation pack, scheduled to be launched in January 2024.

Proposed draft vision statement for 2024-2029

“In Croydon, we envision a future where every resident leads happy, fulfilling lives in safe, healthy and thriving communities. Through working together and focusing on our strengths, we actively tackle inequalities, ensuring this strategy serves as a catalyst for transformative community wellbeing.”

Proposed draft guiding principles for 2024-2029

Based on the above discussions, the following principles are proposed for the revised Strategy for 2024-2029 to guide how the Health and Wellbeing Board will

work in partnership across the health and care system and with the local community to deliver the strategy:

1. **Tackling health inequalities:** work together to tackling inequalities so every resident has an equal opportunity to achieve and maintain good health and wellbeing and live happy and fulfilling lives. This principle highlights the commitment to create a healthy and safe environment that ensures equitable access, outcomes and opportunities for all residents regardless of their background.
2. **Prevention across the life-course:** embrace a comprehensive preventative approach that spans the entire life course, including a specific focus on key transition points. This principle commits to holistic wellbeing by implementing strategies that promote prevention at every stage of life, ensuring a lifelong approach to health and wellbeing for all residents.
3. **Integrated and aligned partnership working:** improving our health and wellbeing and tackling inequalities is everybody's business. This principle commits to working together cohesively and in alignment with a range of partners, ensuring a united approach to community health wellbeing in Croydon.
4. **Community focus and co-production:** ensuring a community focus in all strategies and actions. This principle emphasises collaborative efforts with our community, ensuring that strategies, actions and initiatives are co-created, co-designed and aligned with the unique needs and aspirations of our local residents.
5. **Evidence-informed decisions and actions:** Base strategic decisions and actions on robust evidence, incorporating data-driven insights to ensure that interventions and initiatives are effective, efficient, and aligned with the evolving needs of the community. Establish clear oversight and monitoring processes to ensure strategies and actions are making the intended impact.

Proposed draft priority areas for 2024-2029

The figure below suggests draft priority areas for 2024-2029.

7. Conclusion and next steps

This joint Health and Wellbeing Board and Health and Care Board workshop formed one of the many steps towards Croydon’s revised Joint Local Health and Wellbeing Strategy for 2024-2029.

Next steps include:

- **Community engagement session with Healthwatch Croydon:** Feedback gathered from this workshop informed the design and delivery of the community engagement session developed in collaboration with Healthwatch Croydon. This engagement session was held on 29th November 2023 as part of Healthwatch Croydon’s Annual Meeting. It sought community feedback on the refreshed strategy’s vision and priority areas of focus. Healthwatch Croydon will summarise the findings of this engagement workshop in a separate report.
- **Draft strategy for consultation:** Insights from both the joint Health and Wellbeing Board and Health and Care Board workshop and the Healthwatch Croydon community engagement session as well as previous activities to date will inform the draft strategy for consultation. This draft will focus on revised vision, principles and priority areas for 2024-29.
- **Public consultation and wider engagement:** A formal public consultation on the revised strategy is planned for January-February 2024. There will also be further opportunities to receive community feedback during this time.
- **Final draft of the strategy:** Final draft for the revised strategy, incorporating feedback from the public consultation, is expected to be presented to the Health and Wellbeing Board in March 2024.

8. Appendix I. Agenda and attendee list

Agenda

Item	Lead	Timing
1. Welcome and introductions	Cllr Hopley Mayor Perry	10:00-10:15
2. Overview of workshop aims and agenda	Cllr Hopley	10:15-10:25
3. Revising the vision and principles for the Joint Local Health and Wellbeing Strategy: Background presentation, Q&A and Mentimeter activities.	Jack Bedeman	10:25-11:00
4. 15-minute comfort break	**-**	**11:00-11:15**
5. Small group activity: prioritisation exercise	Shifa Sarica	11:15-12:15
6. **5-minute comfort break**	**-**	**12:15-12:20**
7. Group presentation and discussion	Jack Bedeman	12:20-12:45
8. Summary of agreed priorities for the 2024-29 Strategy	Jack Bedeman	12:45-12:50
9. Next steps and closing remarks	Cllr Hopley	12:50-13:00

Attendees

Name	Job title	Organisation
Mayor Jason Perry	Mayor and co-chair of Health and Care Board (welcome and introduction only)	Croydon Council
Cllr Yvette Hopley	Chair of Health and Wellbeing Board	Croydon Council
Cllr Margaret Bird	Vice Chair of Health and Wellbeing Board	Croydon Council
Cllr Tamar Barrett	Health and Wellbeing Board Member	Croydon Council
Cllr Janet Campbell	Shadow Cabinet Member for Health and Adult Social Care, Health and Wellbeing Board Member	Croydon Council
Annette McPartland	Corporate Director Adult Social Care & Health (DASS)	Croydon Council
Debbie Jones	Corporate Director for Children, Young People and Education	Croydon Council
Matthew Kershaw	Chief Executive and Place Based Leader for Health	Croydon Health Services
Edwina Morris	Chair of Healthwatch Croydon	Healthwatch Croydon

Name	Job title	Organisation
Steve Phaure	Chief Executive Officer	Croydon Voluntary Action
Gordon Kay	Healthwatch Croydon Manager	Healthwatch Croydon
Jack Bedeman	Consultant in Public Health, Public Health Team	Croydon Council
Kerry Crichlow	Director Quality, Commissioning & Performance	Croydon Council
Laura Jenner	One Croydon Programme Manager	One Croydon, Croydon Council
Sue McVicker	Chief Executive Officer	Croydon Neighbourhood Care Association
Andrew Brown	Chief Executive	Croydon BME Forum
Biju Gill	Chief Executive Officer	Croydon GP Collaborative
Leroy Adamson-Parks	Director of IT & Digital Services	Croydon Health Services
Jonathan Northfield		South London and Maudsley NHS Foundation Trust
Shifa Sarica	Public Health Principal, Public Health Team	Croydon Council
Una O'Brien	Public Health Principal, Public Health Team	Croydon Council
Fatai Ogunlayi	Consultant in Public Health, Public Health Team	Croydon Council
Isabella Watson	National Management Trainee, Public Health Team	Croydon Council
Ashwin Venkatakrishnan	National Management Trainee	Croydon Council
Hannah Balzaretti	Interim Head of Improvement, Adult Social Care Policy & Improvement	Croydon Council
Paulette Lewis	Non-Executive Director	Croydon Health Services
Gus Heafield	Chief Financial Officer	South London and Maudsley NHS Foundation Trust

Draft Joint Local Health and Wellbeing Strategy (2024-2029)

Consultation pack

PLACEHOLDER FOR FOREWORD FROM CLLR HOPLEY

Contents

Introduction to the consultation pack

This consultation pack introduces the draft vision, guiding principles and priority areas of focus for Croydon's Joint Local Health and Wellbeing Board for the next five years. The Joint Local Health and Wellbeing Strategy is our roadmap to create a healthier and happier Croydon, where everybody, regardless of their background has an equal opportunity to achieve good health and wellbeing.

Thank you for taking the time to review this pack. Your views are vital in shaping this strategy to meet the unique needs and challenges of our community.

Background

Croydon's Health and Wellbeing Board

Croydon's Health and Wellbeing Board is a statutory board of the Council made up of representatives from the local authority, the NHS, Healthwatch Croydon, our Voluntary and Community Sector, and other key stakeholders. The Board's mission is to ensure that everyone in Croydon, regardless of their background, has an equal opportunity to live a healthy and happy life.

As mandated by the Health and Social Care Act 2012, the Health and Wellbeing Board plays a central role in enabling integrated working across the health and social care sector to improve the health and wellbeing and tackle health inequalities in Croydon. To meet this goal, the Board has the following two core responsibilities:

(1) To assess the health and wellbeing needs of the local population in Croydon through what is known as the Joint Strategic Needs Assessment, and

(2) To produce a Joint Local Health and Wellbeing Strategy that jointly agrees the areas of focus for improving the health and wellbeing of the local population in Croydon.

The Joint Local Health and Wellbeing Strategy

The Joint Local Health and Wellbeing Strategy (JLHWS) sets out how the Health and Wellbeing Board will work together as a partnership, along with residents, to improve the health and wellbeing of our local communities. It is informed by local needs, as identified in the Joint Strategic Needs Assessment (JSNA), and the views of partners and our local communities.

Why are we revising the strategy?

Croydon's current JLHWS was published in 2019. Since then, the health and wellbeing and the health and care system in Croydon, like many other places, have seen important changes.

One of these key changes in the health and care system is the implementation of the Health and Care Act 2022 and the subsequent creation of Integrated Care Systems. Integrated Care Systems are partnerships of organisations that bring together local authorities, NHS organisations and other system partners to plan and deliver joined-up health and care services within a geographical area. Croydon is now a part of the South West London Integrated Care System, which is made up of a total of six local authorities. The other local

authorities in South West London Integrated Care System include Kingston, Merton, Richmond, Sutton and Wandsworth.

With the Health and Social Care Act 2022, Croydon's Health and Wellbeing Board continues to be responsible for the creation of the JLHWS. However, there is now a need to coordinate the JLHWS and the Integrated Care Strategy so that initiatives within Croydon and South West London can have the greatest possible positive impact on our health and wellbeing.

In addition to these changes in the health and care system, the COVID-19 pandemic has shone a light on existing, and in some cases widening, health inequalities in Croydon. The cost-of-living crisis continues to pose significant challenges not only to the health and social care services but also to our health and wellbeing.

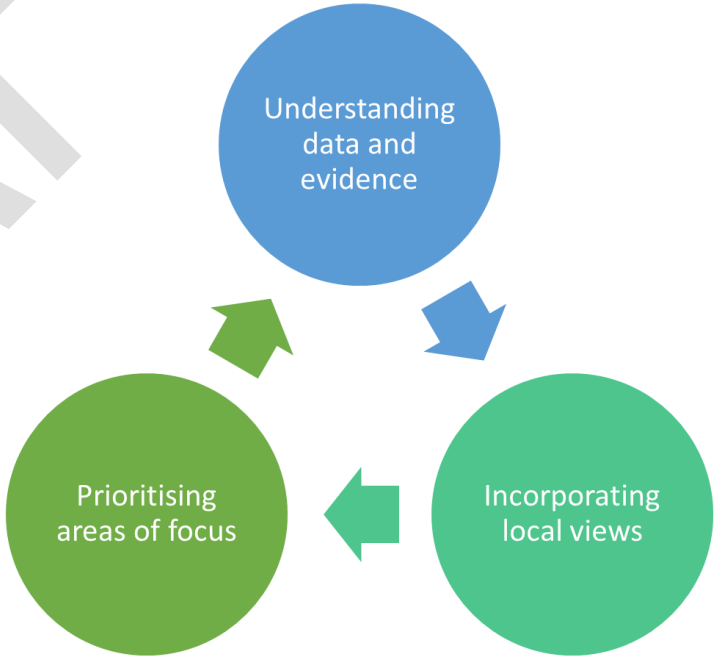
We are committed to keeping our strategy relevant, effective, and responsive to these changes. By reviewing and revising the JLHWS, we want to make sure it stays on track to address the evolving health needs and inequalities in Croydon.

How was the draft JLHWS developed?

Understanding what data and evidence tells us

Our health is shaped by various factors, including the conditions in which we are born, grow, live, work and age. These wider conditions, including our housing, education and skills, work, economic opportunities, the healthcare we receive, our social and community networks and surroundings form the building blocks of health. To create thriving communities, we need the right building blocks in place.

Our Joint Strategic Needs Assessment (JSNA), published at https://www.croydonobservatory.org/jsna, provides up-to-date data, intelligence and insights on our health and wellbeing alongside these building blocks. As a first step, we reviewed the JSNA to understand various health and wellbeing needs in Croydon. You can find a summary of this in the supporting document titled **JSNA Summary-November 2023** [insert hyperlink].



Incorporating local views

In Croydon, we believe improving our health and wellbeing is everybody's business. To ensure the draft strategy reflected the diverse needs and aspirations of our local residents and communities, we took the following steps:

- We reviewed insights gathered from community engagement activities in Croydon since 2018, incorporating input from more than 100 local community engagement events and hearing from more than 3,700 voices.
- Croydon boasts a vibrant community spirit and a longstanding tradition of partnership working with residents. A key example of this is the six Local Community Partnerships working across the borough, as part of the Healthy Communities Together Programme. Each Local Community Partnership has developed its own Community Plan, identifying priority themes for their neighbourhoods to improve health and wellbeing and tackle health inequalities. These priorities informed the draft strategy presented in this consultation pack.
- Lastly, in collaboration with Healthwatch Croydon, we undertook a community engagement session in November 2023. The insights and feedback gathered from this session were integrated into this consultation pack.

Prioritising areas of focus for the next five years

Our review highlighted various needs across our community, acknowledging the diverse challenges our local people face. To refine our focus for the next five years, the Health and Wellbeing Board and the Health and Care Board collaborated in a joint workshop in November 2023, resulting in the five draft priority areas outlined in this consultation pack. These priorities were carefully chosen based on:

- Data and evidence from the Joint Strategic Needs Assessment.
- Alignment with key strategies including the Mayor's Business Plan and the South West London Integrated Care Partnership Strategy.
- Input from community events in the Borough and the Community Plans of six Local Community Partnerships.
- How much positive impact each priority can make on individuals and communities.

We shared and discussed these draft priority areas at the Healthwatch Community Engagement event in November 2023. It is important to note that the purpose of the Joint Local Health and Wellbeing Strategy is not about taking action on everything at once, but about setting a small number of strategic priorities for action, that will make a real impact on people's lives. While many areas did not make it to this consultation pack, this does not mean that we will not work to address them over the next five years.

The draft Strategy for 2024-2029:

Recognising our health and wellbeing as an asset

Our health and wellbeing is shaped by almost everything around us, such as our homes, access to education, quality of jobs and working conditions, strength of our social connections or whether we experience poverty and discrimination. These building blocks are often referred to as 'wider determinants of health.' Existing research shows that healthcare itself contributes to between **15-25%** of our health and wellbeing, while the wider determinants of health shape between **45-65%** of our health and wellbeing (The King's Fund, 2013).

In Croydon, we know that our health and wellbeing is an invaluable asset. It is both vital for our individual wellbeing, enabling us to lead happy and fulfilling lives, and forms the basis for thriving communities. In 2021-22, just under **4 in 5** Croydon residents reported a good life satisfaction score (Office for National Statistics, 2022).

Understanding current challenges and tackling health inequalities

With a population of **390,719** Croydon stands as the largest borough in London. Our population includes a substantial number of both younger and older residents, with around **1 in 4** people **under 18 years** of age and **1 in 7** people **over 65 years** old. The borough's population is projected to reach **408,271 by 2043,** with a smaller proportion of younger and larger proportion of older people, emphasising our changing population structure.

Croydon has a vibrant and diverse population. Around **52%** of the people in Croydon are from Black, Asian, and Minority Ethnic groups. Around **84%** of our residents speak English as their main language. After English, the most common main languages are South Asian languages (4.8%), Other European (EU) languages (4.7%), Portuguese (1.3%), Spanish (1.0%), and East Asian languages (0.8%).

Despite our diversity, not everyone in Croydon has the same opportunities to lead a healthy life. This is known as **health inequalities**, which are unfair and avoidable differences in health between different groups of people (Kings Fund, 2022).

"Health inequalities are unfair and avoidable differences in health between different groups of people."

The latest data shows that during 2018-2020, the average life expectancy in Croydon stood at **79.7 years** for men (19th in London), and **83.7 years** for women (25th in London). However, men residing in the most deprived areas in Croydon were expected to live **9.2 years** less than their counterparts living in the least deprived areas. Similarly, women in the most deprived areas were expected to live **6.5 years** less than those living in the least deprived areas.

The COVID-19 pandemic has further increased these health inequalities within our borough. We know that the COVID-19 pandemic did not impact everyone equally: specific groups, particularly those with the lowest incomes and our Black, Asian and Minority ethnic communities have borne the brunt of its impact. Current economic challenges, such as the rising cost of living, place a growing strain to the lives of our residents, impacting their ability to meet basic needs and lead healthy and fulfilling lives.

These pressing challenges underscore our commitment to achieving a Croydon, where every resident, regardless of background, has equitable opportunities for a healthy and fulfilling life. At the heart of the JLHWS is the recognition that health and wellbeing is everybody's business. By working together and using our resources efficiently, we can make a meaningful difference in the health and wellbeing of our residents.

Our vision

Our vision for health and wellbeing in Croydon sets out what we want to achieve in the long term.

In Croydon, everybody is enabled to lead a healthy, happy and fulfilling life supported by safe, healthy and thriving communities and neighbourhoods. We work together and build on our strengths to actively tackle inequalities and improve our health and wellbeing.

Our guiding principles

Our guiding principles will underpin our actions over the next five years.

1. Tackling health inequalities

We will aim to reduce, and where possible prevent, health inequalities. In addition to taking action to improve the health and wellbeing of everybody in Croydon, we will take action to:

- Improve the health of the most disadvantaged groups, and
- Reduce the gap between the best and the worst off.

This includes building on our commitments stated in **Croydon's Equality Strategy** and our adoption of the borough-wide **Equalities Pledge** and **George Floyd Race Matters Pledge** to positively promote the equality of opportunity for individuals of all characteristics, with a specific focus on underserved groups such as minoritised ethnic groups, LGBTQ+ communities, refugees, asylum seekers, homeless people, and people with disabilities including those with communication impairments.

2. Prevention across the life course

We will take a prevention-first approach to prevent ill health from happening in the first place. We will embed principles of prevention across the life course, ensuring that our residents have the necessary tools and support, especially during key transition stages, to lead healthy and independent lives. We will aim to identify and tackle issues at the earliest possible opportunity to prevent them from getting worse.

3. Integrated partnership working

We will continue to improve integrated partnership working across health and social care at the local level, capitalising on the accomplishments of the One Croydon Alliance. We will actively engage in integrated partnership initiatives throughout South West London. We will endeavour to use our collective resources effectively, efficiently and sustainably, enabling our residents to find the right support, at the right time and at the right place.

4. Community focus and co-production

We are committed to taking a community-centric approach striving to shift more services to community settings, enabling community-led support to improve health and wellbeing. We will work in partnership with our residents and communities, recognising and building on their strengths.

5. Evidence-informed decisions and actions

We will base our strategic decisions and actions, including our commissioning, on the best available evidence. This principle ensures that our actions are effective, efficient, and aligned with the evolving needs of our communities. We will establish clear oversight and monitoring processes to assess the impact of our strategies and actions.

Draft priority 1: Good mental health and wellbeing for all

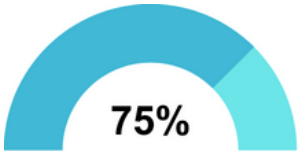
Mental health is a 'state of mental wellbeing that enables people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community' (World Health Organisation, 2022). In Croydon, we recognise that there is **no good health without good mental health** and **promoting and protecting good mental health is everybody's business**.

Our mental health is shaped by many factors, some of which start before the time we are born. While individual factors such as our genetics and health-related behaviours do impact our mental health, wider determinants of health such as our housing and work conditions, income, education, families, communities and neighbourhoods act as crucial foundations for our mental wellbeing. Our mental and physical health are connected. While physical health problems could increase our risk of developing mental health problems, mental health problems could put us in a higher risk of physical health issues.

Building on the success of the ongoing **Mental Health Transformation Programme**, which aims to deliver preventative and person-centred mental health care to our residents, we will continue to work to ensure our residents can get the help and support they need at the place and the time they need it.

We will continue to focus on promoting mental wellbeing, preventing mental health conditions, and preventing self-harm and suicide. Working as a whole system and across organisational boundaries, we will take action to ensure our residents have access to the tools they need to achieve and maintain good health and wellbeing throughout their lives. We will support the development of **Croydon's Multiagency Self-harm and Suicide Prevention Action Plan**, as well as supporting the development of **Croydon's Dementia Strategic Plan and Action Plan and Autism Strategy**. In line with the **South West London Mental Health Strategy,** we will work with our partners, to promote positive mental health promotion and prevent ill-mental health across our borough.

1 in 4 people expected to have a mental health problem at some point in their life.



Of mental health problems develop by the age of 24.

Around 56,852

adults over 16 years in Croydon could be currently experiencing a common mental health problem (estimates based on 2017 data).

Around 10,000

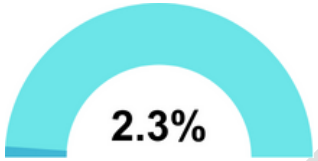
children and young people aged 6-16 years estimated to have a probable mental disorder in Croydon.

Draft priority 2: Cost of living: supporting our residents to 'eat, sleep and have heat'

Access to quality housing, that is warm, secure and can support independent living, as well as adequate healthy food are important for our health and wellbeing. To effectively tackle health inequalities, we need to ensure all residents have access to affordable quality housing and healthy food.

Croydon has some of the most deprived areas in London and England. While the recent cost-of-living crisis has affected almost everyone in the UK, the rising prices have most severely impacted those on the lowest incomes. We have already heard from our residents that many on lower incomes are struggling to afford paying for food and energy bills with some having to choose between eating and heating. The lasting consequences of the rising cost of living have the potential to impact many generations and worsen health inequalities.

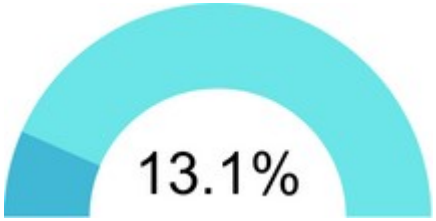
We will work across organisational boundaries to mitigate the impacts of the cost of living and where possible prevent people from slipping into poverty. To support our residents with challenges of cost of living, we will establish a multiagency **Cost of Living Action Group**. Through this group, we will bring together new and existing support available locally and nationally in one place to make it easier for our communities to access the support they need when they need it and where they need it. To do this, we will build upon existing partnerships and initiatives in the borough, including **Community Hubs** and the **Croydon Food and Healthy Weight Partnership**. Working with our partners and communities with lived experience of poverty, we will develop solutions that provide immediate emergency and welfare support while fostering resilience within our communities.



Of small areas in Croydon are among the most 10% deprived areas in England.

Around **3 in 5** people living in the most deprived areas in Great Britain were buying less food in 2022 compared with 2021.

Around **1 in 3** children under 16 years experience poverty (Child poverty rates, 2021/22).



21,165 households in Croydon were experiencing **fuel poverty** (2021).

Draft priority 3: Healthy, safe and well-connected neighbourhoods and communities

Our health and wellbeing is shaped by the places in which we live, play, work and socialise in addition to the relationships and resources we have in our communities. Recognising this, our strategy puts an important focus on cultivating healthy, safe and well-connected neighbourhoods and communities, where healthy choice becomes the easy choice.

We will work to make our neighbourhoods healthy and safe, where our residents can easily access affordable, healthy food and enjoy clean air. We would like our neighbourhoods to have increased opportunities for active travel and physical activity, to make it easier for our residents to attain and maintain healthier lifestyles.

Croydon boasts vibrant and diverse communities, and a strong Voluntary and Community Sector. We will build on our close relationships with our Voluntary and Community Sector and our local community to establish community-led initiatives that aim to foster a strong sense of belonging and help our communities thrive. We want to ensure our services are **culturally competent** and be a leader for South West London around establishing the use of an **anti-racism framework**. This includes building on our commitments stated in **Croydon's Equality Strategy** and our adoption of the borough-wide **Equalities Pledge** and **George Floyd Race Matters Pledge** to positively promote the equality of opportunity for individuals of all characteristics, with a specific focus on underserved groups such as minoritised ethnic groups, LGBTQ+ population, refugees, asylum seekers, homeless people, and people with disabilities including those with communication impairments.

Our **Healthy Communities Together Programme,** a partnership programme between the Voluntary and Community Sector, the NHS and Croydon Council works to improve health and wellbeing, reduce health inequalities and empower communities across our six localities.

Our **Community Hubs** offer holistic support to our communities, covering advice on housing, benefits and health checks. They see over 2,000 people each year and are a place for our residents to meet and connect with others.

Just over **3 in 5 (62.0%)** adults are overweight or obese (2021/22).

Just over **3 in 5 (61.9%)** physically active adults in Croydon (2021/22).

Just under **1 in 7 (13.5%)** adults over 18 are estimated to be smoking in Croydon.

40,437

Offences in Croydon in the rolling months to September 2022 (15th highest rate in London out of 32 boroughs).

Draft priority 4: Supporting our children, young people and families

Croydon has the largest population of children and young people in London. In 2021, **90,241** individuals in Croydon were under 18 years old, and just over a third (33.8%) of our households had dependent children. Detailed data on Croydon's children, young people and families can be found at our children, young people and families JSNA.

1 in 4 people in Croydon is under 18 years old.

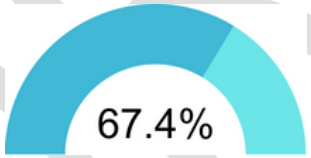
Our first 1,001 days in life, covering the period from pregnancy to the age of 2, set the foundations for our lifelong health and wellbeing. Health inequalities that affect us throughout our lives can start before we are born. To tackle health inequalities and set the stage for a lasting healthy life, we need to prioritise our early years and ensure our babies get a good start in life. This involves providing parents and carers with access to high-quality, joined-up primary care, antenatal, maternity, children and family services.

We will support our parents, carers and families in their communities, addressing both health and social care needs, including any pregnancy concerns. We will promote the mental health and emotional wellbeing of parents and carers as well as all children and young people in Croydon. We will take a **whole-family approach** and take action from before and during pregnancy through to childbirth and throughout childhood to enable our children and young people to thrive in life and create a positive impact for generations to come. We will support the implementation of **Croydon's Partnership Early Years Strategy**. Building on our **Family Hubs and Start for Life Transformation Programme,** we will work to ensure our families have access to the information and tools they need to support their babies and children, and to look after their own wellbeing.

Childhood vaccination rates in Croydon **fall below** the 95% target levels.

310

Hospital admissions were recorded for dental caries among 0-to-5 year olds in Croydon between 2018-2021.

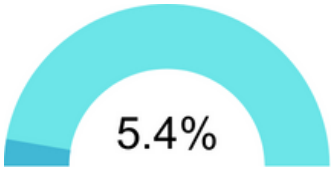


School readiness at the end of reception (2021/22, similar to London).

Just over **1 in 5** (22%) children in reception years (4-5 years old) were overweight or obese (2021/22, similar to London).

9,041

7-to-16 year olds estimated to have a probable mental disorder in Croydon (Mental Health of Children and Young People in England Survey).



16 year olds were not in Education, Employment or Training (2021, higher than London).

Draft priority 5: Supporting our older population to live healthy, independent and fulfilling lives

By 2041, just over 1 in 5 people in Croydon are expected to be over 65 years old. Our older residents are more likely to experience complex, long-term health conditions, and are at increased risk of falls and frailty. They are also likely to experience mental health issues due to factors such as loneliness and social isolation.

Our older residents have told us that to remain healthy and happy and live fulfilling lives:

- They would like to be able to self-care and live independently.
- They would like to have strong community connections and take part in physical and social activities, for example through dedicated physical exercise classes for older people or cultural celebrations.
- They would like to have accessible health and care services and have the information they need in a clear and understandable language.

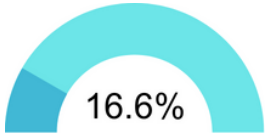
We want to enable our older residents to stay physically and mentally well and maintain independence for as long as possible. We would like them to have long and fulfilling lives, be treated with dignity and respect, including at the end of their lives, focusing on both living well and dying well at the end of life.

To do this, we will support our residents with long-term conditions, helping them to manage their own conditions and improving the care they receive through **Croydon's Proactive and Preventative Care Model.** We will use innovative, data-driven methods, through our **Population Health Management Programme**, to identify and support residents to manage their frailty and prevent their frailty from deteriorating. We will continue to focus on frailty through our **ICN+ Programme** to ensure people who have been identified as frail are supported in a holistic way. We will support the delivery of **Croydon's Dementia Strategic Plan** and work with our partners to ensure Croydon progresses as a **dementia-friendly borough**. Building on our strong Voluntary and Community Sector, we will work with our older people, to **tackle loneliness and social isolation** and **increase opportunities for physical and social activities**.

In 2021**, 1 in 7** people in Croydon is over 65 years old.

1,908 per 100,000
emergency hospital admissions due to falls in people aged 65 and over (2021/22, better than England).

2,669
people aged 65 and older estimated to have dementia in Croydon (2023).



Adults (18+ years) who feel lonely at least some of the time (2019/2020, better than London).

Just over **1 in 3** (33.7%) adult social carers over 65+ years feel they have as much social contact as they would like (2021/22, similar to London).

Next steps:

Finalising the strategy

Your views will be incorporated into the final strategy scheduled to be published in 2024.

Delivering the strategy

Our strategy is not a standalone effort for improving our health and wellbeing and tackling inequalities in the borough. It is aligned with key initiatives such as the Mayor's Business Plan and the South West London Integrated Care Strategy.

The strategy will be delivered through coordinated, partnership efforts of organisations represented on the Health and Wellbeing Board as well as others. The Health and Wellbeing Board will provide leadership in addressing the priority areas set in the strategy. The Health and Care Board, and their affiliated groups and boards, will support the Health and Wellbeing Board in delivering the ambitions set out in this strategy.

We will set up partnership working groups for each priority area to co-produce action plans with measurable outcomes. We recognise that the priorities set in our strategy are interconnected and actions in one area can significantly impact others. Therefore, these working groups will ensure a cohesive approach, fostering collaboration across different areas to maximise our impact.

Monitoring success

We will develop an outcomes and monitoring framework with key performance indicators to track progress towards our goals. Through this monitoring framework, we will remain responsive to our communities' evolving needs, and adjust our strategy and action plans as necessary.

Draft Joint Local Health and Wellbeing Strategy (2024-2029) on a page

The draft Joint Health and Wellbeing Strategy sets out our shared vision for a healthier, happier and safer Croydon. Over the next five years, we will focus our collective efforts in five key areas to make meaningful strides towards this vision. Our guiding principles will steer every decision and action we take in these areas.

Our vision describes what we want to achieve in the long term

Our guiding principles steer our decisions and actions

Our strategic priorities outline the areas we will focus our efforts on over the next 5 years to achieve our vision

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The Health and Wellbeing Board, a statutory board of Croydon Council, is made up of the following partners:

CROYDON
www.croydon.gov.uk

NHS 75
Croydon Health Services
NHS Trust

healthwatch
Croydon

NHS
South London
and Maudsley
NHS Foundation Trust

Representing the Community and Voluntary Sector on the Board:

croydonvoluntaryaction
since 1907

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Understanding our Health and Wellbeing: A summary of Croydon's Joint Strategic Needs Assessment

Public Health Team

November 2023

CROYDON
www.croydon.gov.uk

Note to the reader:

Please note that this pack summarises Croydon's JSNA as at November 2023. Readers should note that more up-to-date data may have been subsequently published and are advised to refer to the live digital JSNA at https://www.croydonobservatory.org/jsna for the latest information.

Contents

This summary slide pack presents an overview of the key insights from Croydon's Joint Strategic Needs Assessment.

Please refer to the main JSNA website at https://www.croydonobservatory.org/jsna/ for detailed discussion of the topics summarised in this slide set.

The key topics covered in this slide pack are listed on the right-hand side.

Introduction

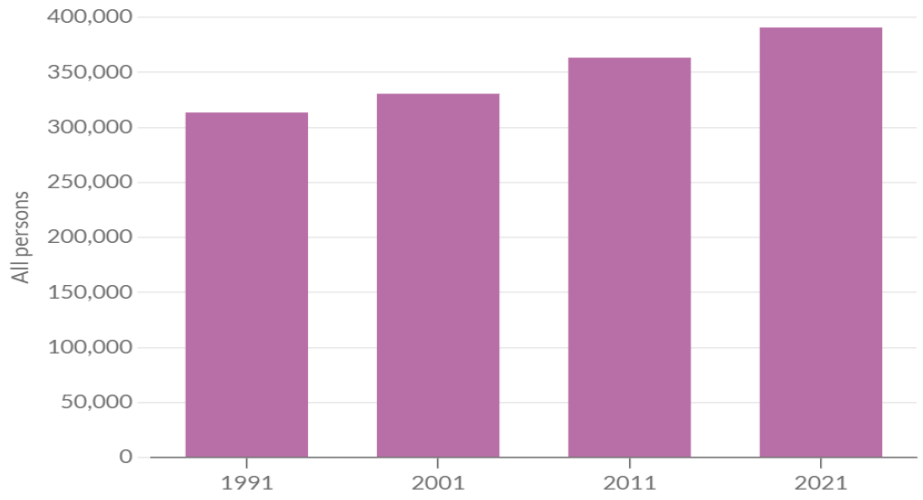
Croydon's Joint Strategic Needs Assessment

- As part of their statutory duties, Croydon's Health and Wellbeing Board produces the Joint Strategic Needs Assessment (JSNA).
- Since 2017, the JSNA is published online at https://www.croydonobservatory.org/jsna/.
- Providing up-to-date data, intelligence and insights on the health and wellbeing outcomes and factors affecting these outcomes, Croydon's digital JSNA provides a first port-of-call for understanding the state of health and wellbeing alongside relevant gaps and needs in Croydon.
- The digital JSNA is structured as themed sections covering the following:
    - **Population overview:** focusses on Croydon's overall population and their general health and wellbeing
    - **Population groups:** provides data and intelligence on specific populations, covering specific localities, various demographic groups and vulnerable population groups.
    - **Wider determinants:** focusses on factors that shape health and wellbeing including education, environment, housing and employment.
    - **Healthy behaviours:** focuses on individual actions impacting health and wellbeing, ranging from physical activity, sexual health, oral health, smoking, and alcohol and substance use.
    - **Health conditions:** focuses on specific diagnosed conditions, including mental health, self-harm and suicide prevention and the Pharmaceutical needs Assessment.
- This evidence summary offers a high-level view of the state of health and wellbeing in Croydon, as informed by the JSNA. For a detailed discussion of the topics covered here, please visit the live JSNA at https://www.croydonobservatory.org/jsna/.

Our population: population estimates, projections and age groups

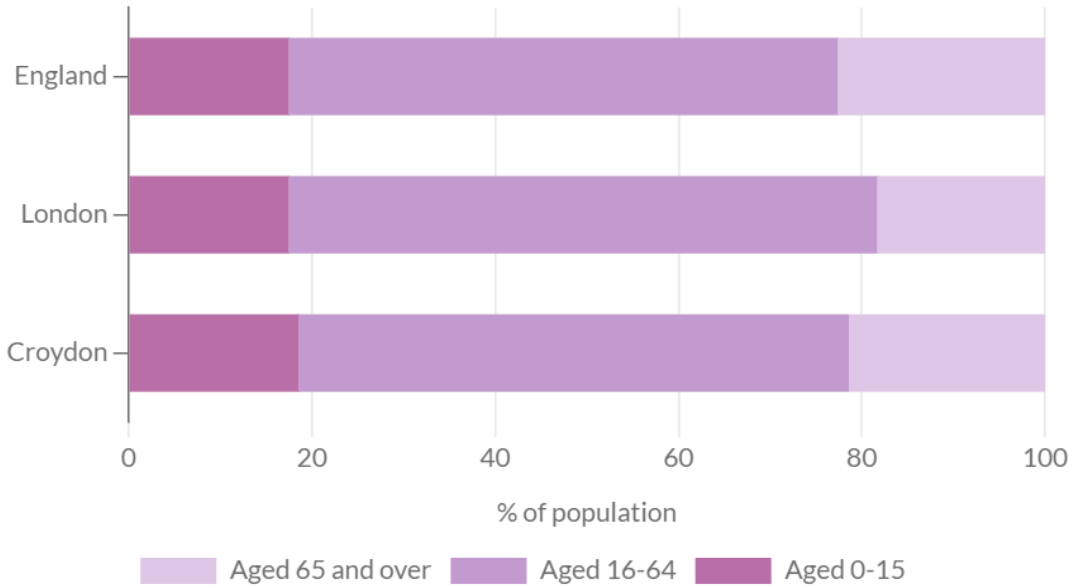
- With a population of **390,719** (Census 2021), Croydon is the largest and one of the most diverse boroughs in London. This section summarises key insights presented in the '[Population profile]' on Croydon Observatory.
- The 2021 Census estimated that Croydon's population grew by **7.5%** since 2011, while overall population of London grew by 7.7%. The figure below shows change in Croydon's population since 1991.
- **By 2043**, Croydon's population is projected to grow to **408,271**. The figure on the right-hand side illustrates population projections by age group in Croydon, London and England.

Change in the population in Croydon from 1991 to 2021:



Source: Office of National Statistics.

Population projections for Croydon, by broad age group, 2043:



Source: Office of National Statistics.

- Croydon has a relatively large population of younger and older people.
  - Please see page 5 for a breakdown of Croydon's population by age group in 2021 and page 6 for the distribution of Croydon's population by age group.
  - According to Census 2021, about **1 in 4 people in** Croydon are under **18 years old**. This proportion is expected to reduce by 2041.
  - Around **1 in 7 people in** Croydon are over 65 years old. This proportion is expected to increase by 2043.

Our population: age groups, ethnicity and languages

Croydon's population by age group, 2021.

Source: Office of National Statistics.

- **Croydon has a diverse population:**
  - Detailed information on various population groups in Croydon, including protected characteristics, can be found at https://www.croydonobservatory.org/ons-census-2021-croydon-highlights-from-each-data-release/. This section provides a snapshot on ethnicity and the most common main languages, only.
  - About **52%** of the population are from Black, Asian and Minority Ethnic groups,
  - Around **5 in 6 (84%)** of people speak English as their main language. After English, **South Asian (4.8%) languages, Other European (EU) language (4.7%), Portuguese (1.3%), Spanish (1.0%) and East Asian (0.8%)** are the most common main languages.

Ethnicity in Croydon (2021):

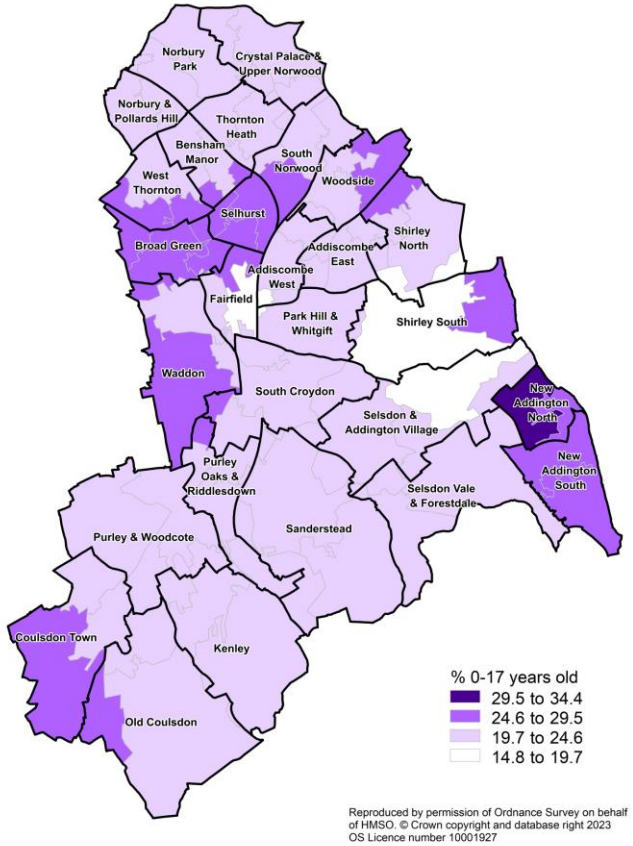
Ethnic group	Croydon	London	England
Asian, Asian British or Asian Welsh	68,487	1,817,640	5,426,392
Asian, Asian British or Asian Welsh (%)	**17.5**	**20.7**	**9.6**
Black, Black British, Black Welsh, Caribbean or African	88,441	1,188,370	2,381,724
Black, Black British, Black Welsh, Caribbean or African (%)	**22.6**	**13.5**	**4.2**
Mixed or Multiple ethnic groups	29,745	505,775	1,669,378
Mixed or Multiple ethnic groups (%)	7.6	5.7	3
White	188,985	4,731,172	45,783,401
White (%)	**48.4**	**53.8**	**81**
Other ethnic group	15,066	556,768	1,229,153
Other ethnic group (%)	**3.9**	**6.3**	**2.2**

Source: Office of National Statistics.

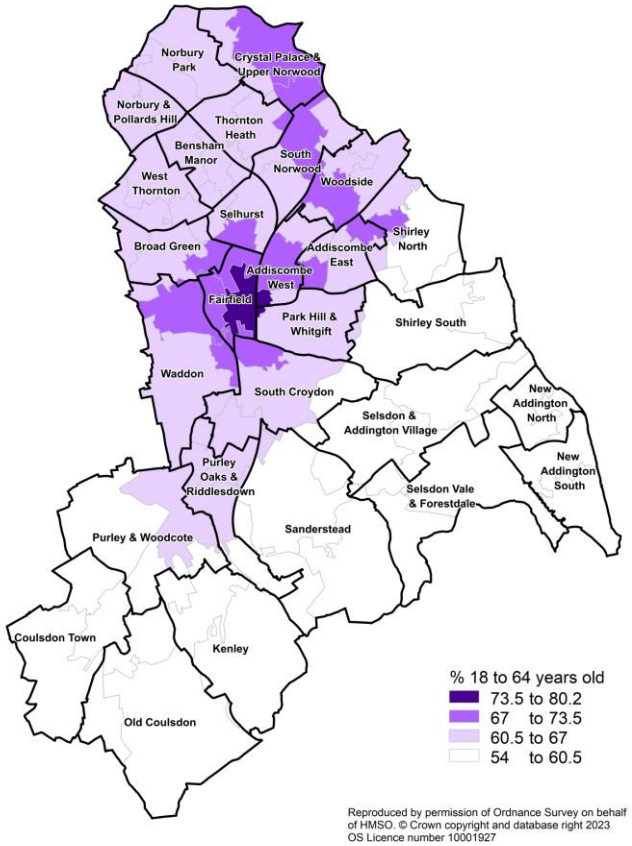
Our population: age group distribution across Croydon

Age group distribution across Croydon, 0-17 years, 18-64 years and 65+ years:

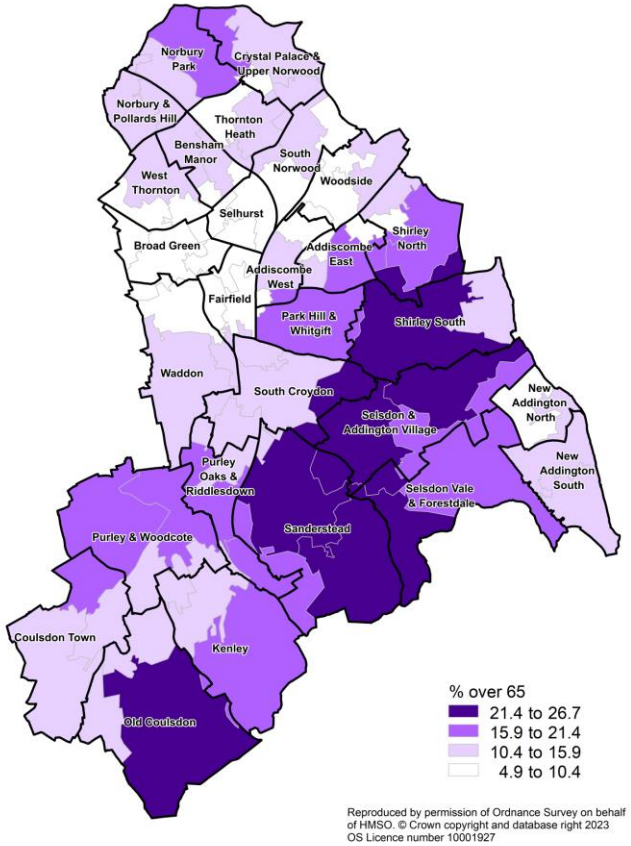
% of population who are 0-17 years old 2021 Census



% of population who are 18-64 years old 2021 Census



% of population who are 65+ years old 2021 Census

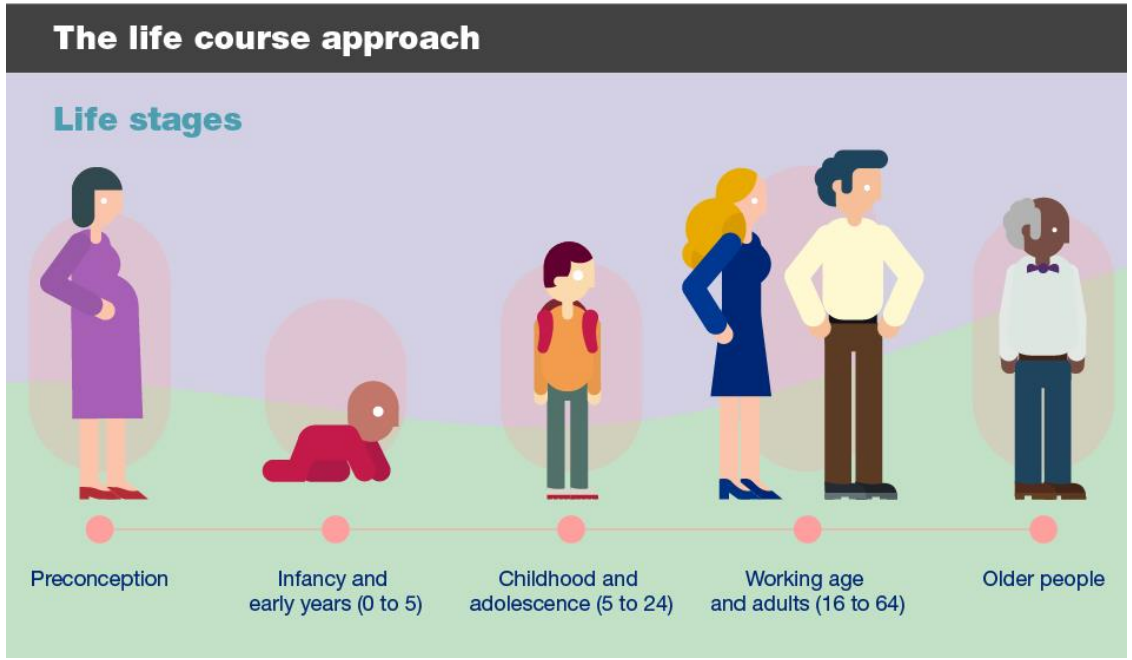


Source: Office of National Statistics.

Understanding our health and wellbeing using a life course approach

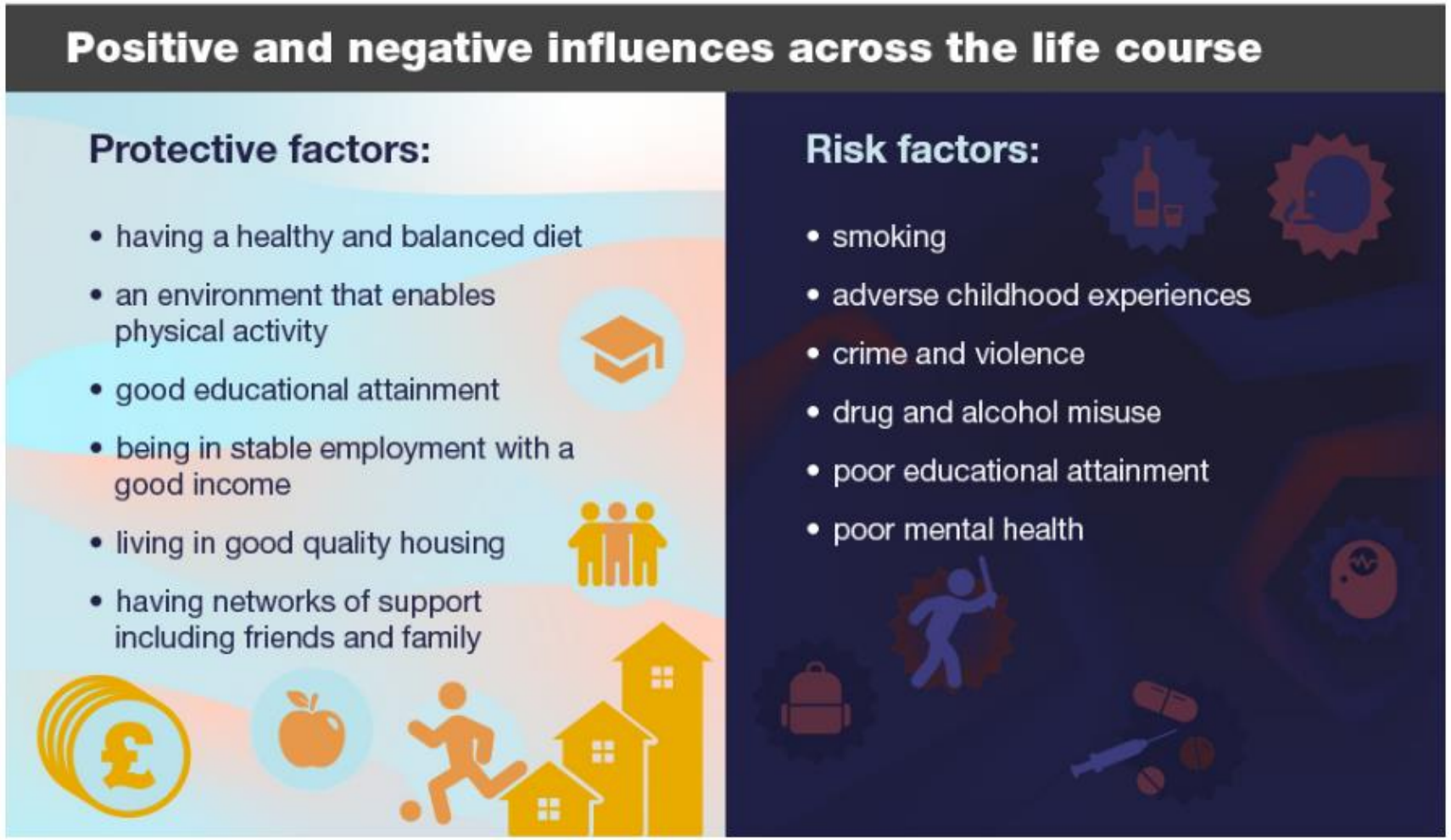
What is the life-course approach?

- In Croydon, we understand that our health and wellbeing, including the length and quality of our lives as well as our satisfaction and happiness, are intricately shaped by various aspects of our lives, including our work, living conditions, educational opportunities and many other factors. Please see the section on building blocks of health and wellbeing, often referred to as 'the wider determinants of health,' for further information on these factors.
- The life-course approach allows us to see every stage of our lives as connected not just to each other but also to the lives of those around us and the generations before and after us. Rather than focusing on specific health conditions during a specific life stage, this approach reminds us to consider both protective and risk factors for good health and wellbeing throughout our life-course, ensuring that we are taking early action to:
    - promote a good start in life,
    - support our communities during key transition periods, and
    - work together to create environments that support everyone's wellbeing, including that of current and future generations, so that everyone can live independent and fulfilling lives for as long as possible.
- The figure on the right-hand side illustrates the key transition stages, that are considered critical stages during a person's life, where large differences can be made in promoting or restoring health and wellbeing. The next page shows some positive and negative influences across the life course that could make a difference in our overall health and wellbeing.
- Croydon's Journey of Life, depicted on page 9, summarises the most recent data on our health and wellbeing using these key transition stages. Comparisons to London averages are also available in this slide.



Adapted from Health Matters: Prevention – a life course approach. Available from https://www.gov.uk/government/publications/health-matters-life-course-approach-to-prevention/health-matters-prevention-a-life-course-approach

Understanding our health and wellbeing using a life course approach



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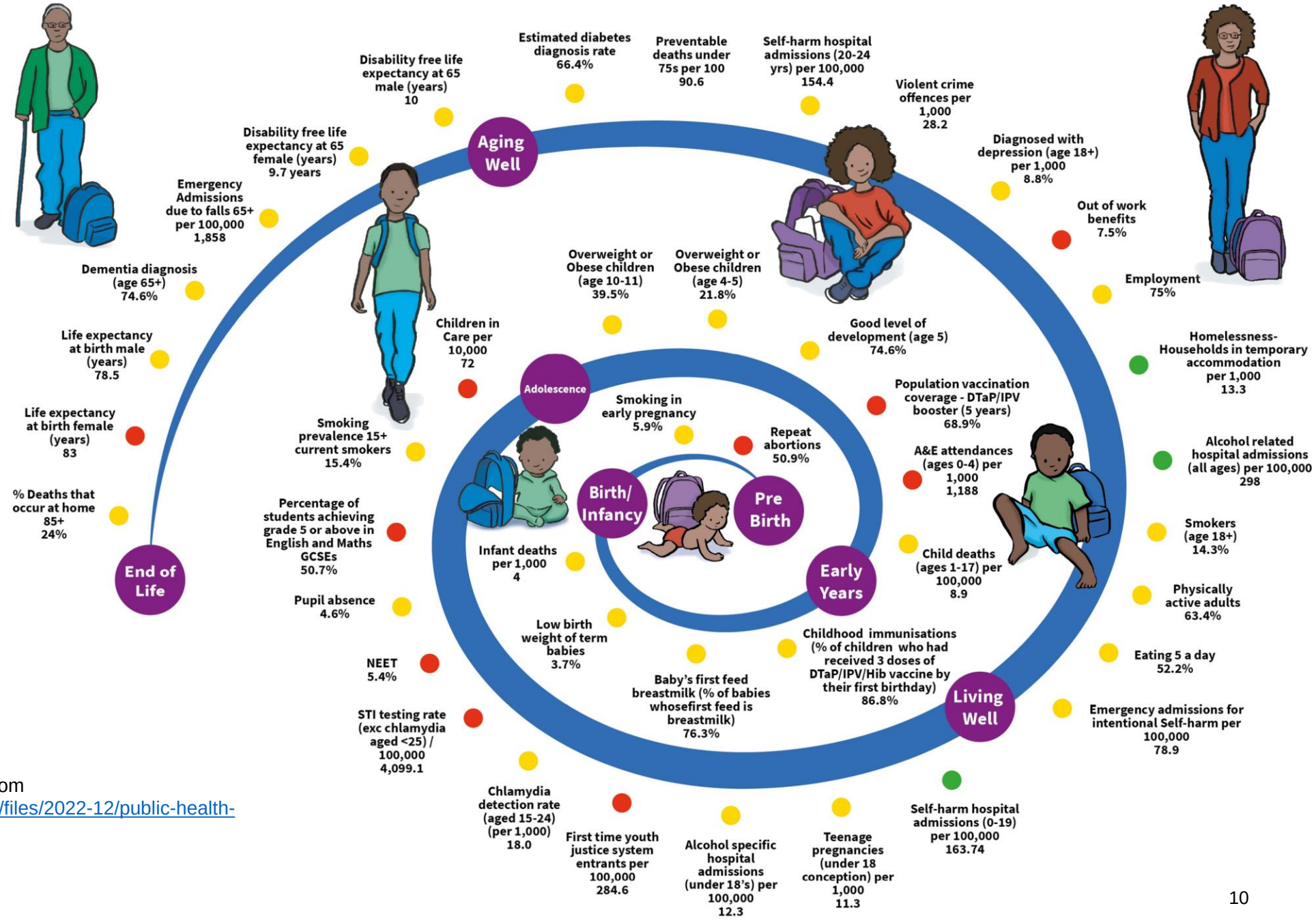
Croydon's Journey of Life (2022)

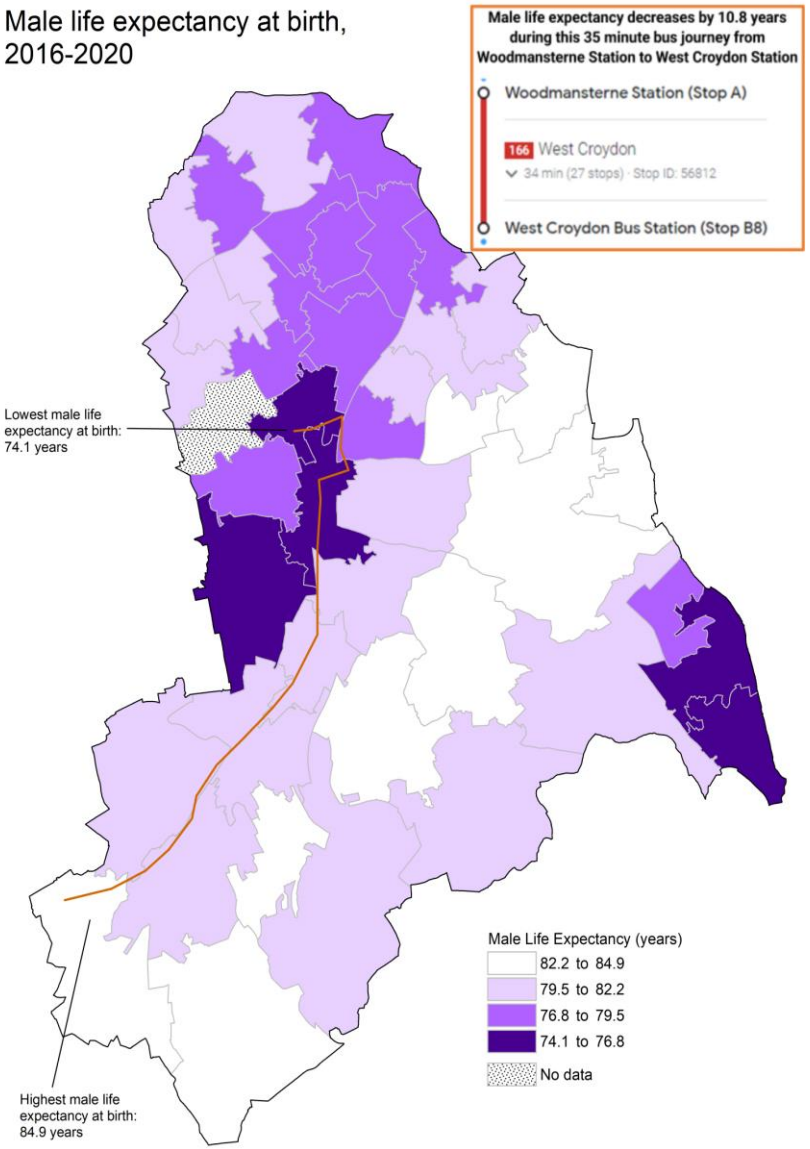


Adapted from ADPHR 2022. Available from https://www.croydon.gov.uk/sites/default/files/2022-12/public-health-report-2022-full-report.pdf

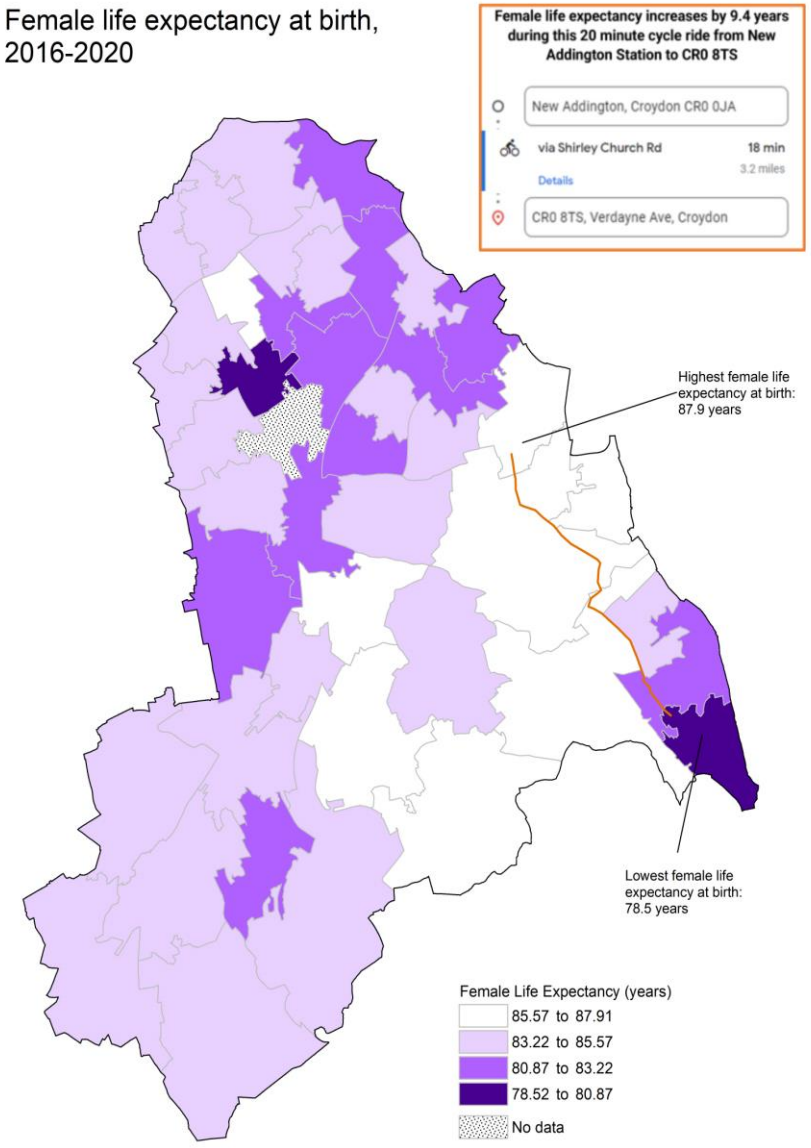
Life expectancy at birth

- Life expectancy at birth is a statistical measure that estimates the average number of years a newborn born in a specific year and geography is expected to live if current death rates do not change.
- During **2018-2020**, the average life expectancy for males and females in Croydon were **79.7 years** and **83.7 years,** respectively.
- Life expectancy at birth for males and females varies across Croydon. Maps on the right-hand side shows life expectancy across Croydon for males and females for **2016-2020**. Darker colours correspond to lower life expectancy. White shades denote areas with the highest life expectancy.
- Between **2016-2020**, the lowest life expectancy at birth for males was **74.1 years** in Central West Croydon near Fairfield, Broad Green and Selhurst. The highest male life expectancy at birth was **84.9 years** in South West Croydon in Coulsdon Town.
- During the same time, lowest female life expectancy at birth was **78.5 years** in South East in New Addington South and the highest female life expectancy at birth was **87.9 years** in Central East Croydon in Shirley North.

Male life expectancy at birth, 2016-2020

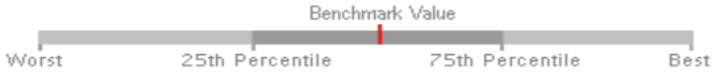


Female life expectancy at birth, 2016-2020



Life expectancy at birth: comparisons with London region (2018-2020)

Better 95% Similar Worse 95% Not applicable Quintiles: Best Worst Not applicable



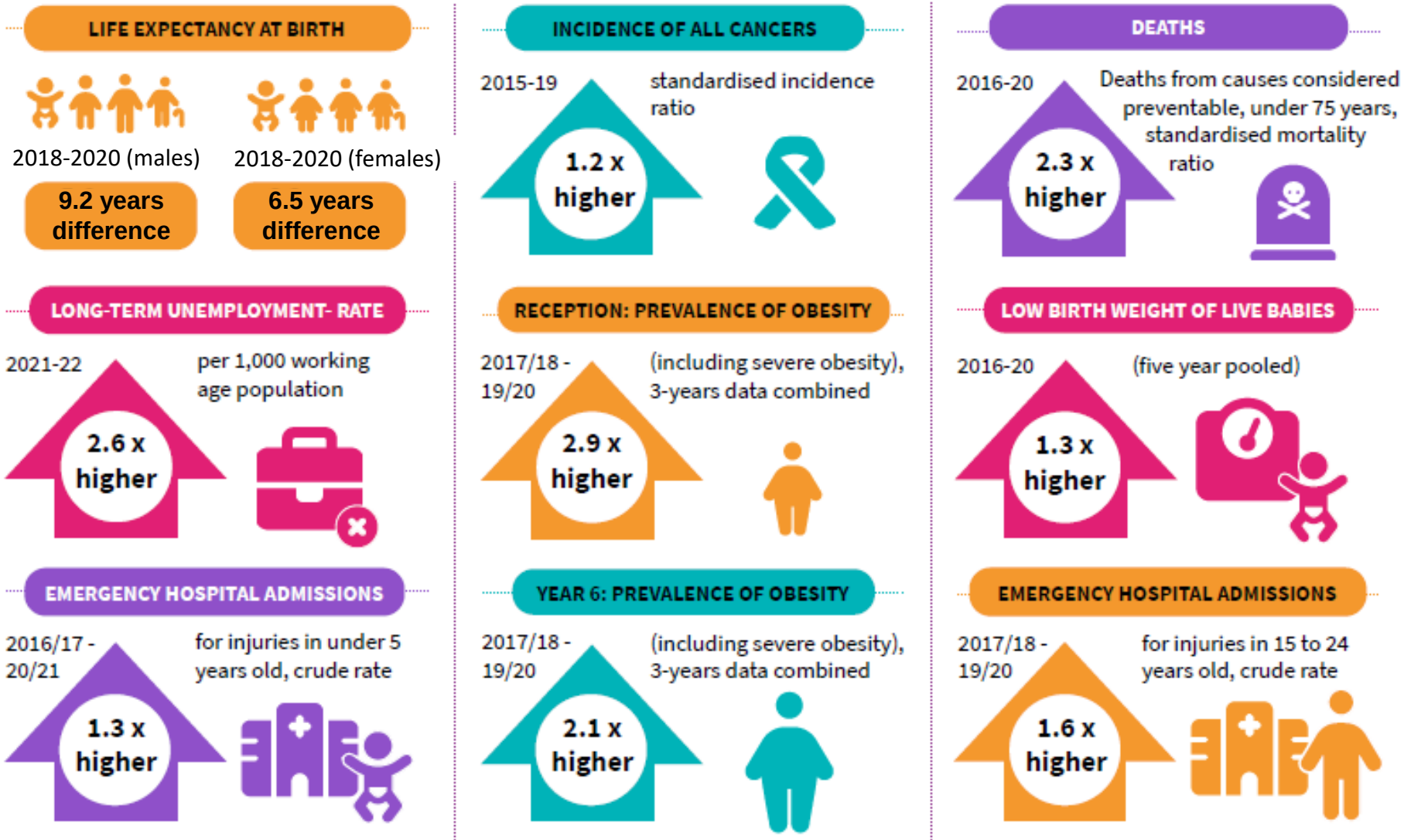
Indicator	Period	Croydon			Region England		London		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Healthy life expectancy at birth (Male)	2018 - 20	–	-	63.2	63.8	63.1	58.1		
Healthy life expectancy at birth (Female)	2018 - 20	–	-	62.4	65.0	63.9	57.8		70.1
Life expectancy at birth (Male)	2018 - 20	–	-	79.7	80.3	79.4	77.0		
Life expectancy at birth (Female)	2018 - 20	–	-	83.7	84.3	83.1	81.7		
Life expectancy at 65 (Male)	2018 - 20	–	-	18.9	19.2	18.7	16.7		
Life expectancy at 65 (Female)	2018 - 20	–	-	21.4	22.0	21.1	19.8		
Inequality in life expectancy at birth (Male)	2018 - 20	–	-	9.2	7.5	9.7	17.0		2.6
Inequality in life expectancy at birth (Female)	2018 - 20	–	-	6.5	5.4	7.9	11.9		1.2
Inequality in life expectancy at 65 (Male)	2018 - 20	–	-	5.0	4.8	5.2	12.7		2.2
Inequality in life expectancy at 65 (Female)	2018 - 20	–	-	5.0	3.6	4.8	7.8		0.1
Healthy life expectancy at 65 (Male)	2018 - 20	–	-	11.2	10.3	10.5	5.9		
Healthy life expectancy at 65 (Female)	2018 - 20	–	-	10.1	11.2	11.3	6.9		
Disability-free life expectancy at 65 (Male)	2018 - 20	–	-	10.0	10.3	9.8	6.2		
Disability-free life expectancy at 65 (Female)	2018 - 20	–	-	9.7	10.2	9.9	7.6		
Disability free life expectancy at birth (Male)	2018 - 20	–	-	63.8	64.4	62.4	58.2		68.9
Disability free life expectancy at birth (Female)	2018 - 20	–	-	60.0	63.3	60.9	54.5		68.8

Source: Office of Health Improvement and Disparities

Health inequalities

- Health inequalities are '**avoidable, unfair and systematic differences** in health between different groups of people.' They can involve differences in:
    - health, for example, how long a person lives and whether they have illness and disease;
    - access to care, for example, availability of a given service to support their health;
    - quality and experience of care, for example, levels of patient satisfaction;
    - behavioural risks to health, for example, smoking or alcohol use,
    - wider determinants of health, for example, quality of housing or employment. (The King's Fund, 2022)
- Health inequalities exist in many forms. Therefore, when trying to identify them, it is important to consider:
    - What they concern (*Health inequalities **in what?**).* For example, health inequalities could involve differences in:
        - Health status (for example, life expectancy)
        - Access to care (for example, availability of services)
        - Quality and experience of care (for example, levels of patient satisfaction)
        - Behavioural risks to health (for example, smoking rates)
        - Wider determinants of health (for example, quality of housing)
    - Who is experiencing them (*Health inequalities **between whom?**).* For example, we can look at differences between different populations grouped by:
        - specific individual characteristics, some of which we are born with, for example, genes, sex, ethnicity and disability,
        - geography, for example urban vs rural populations,
        - wider socio-economic factors, for example, household income, work environment, and
        - social, economic or health-related vulnerabilities. For example, homeless individuals, refugees and asylum seekers. (The King's Fund, 2022)
- The next page summarises key health inequalities observed in Croydon based on deprivation as defined by Index of Multiple Deprivation. A detailed focus on health inequalities in Croydon can be found in the 2022 Annual Director of Public Health Report. More information on the Index of Multiple Deprivation is found in the deprivation section.

Health inequalities associated with deprivation as defined by Index of Multiple Deprivation 2019



Adapted from ADPHR 2022. Available from https://www.croydon.gov.uk/sites/default/files/2022-12/public-health-report-2022-full-report.pdf

Spotlight on Mental Health and Wellbeing

- Mental health is ‘a state of mental wellbeing that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community.’ (World Health Organization).
- In Croydon, we see good mental health and wellbeing as a key pillar of our overall health and wellbeing. We also regard promoting and improving our mental health and wellbeing as everybody’s business.
- National surveys suggest that in 2021, **1 in 9** children and young people aged between 6 and 16 years had a probable mental health disorder in the UK (Newlove-Delgado et al. 2021). For Croydon, this would correspond to around **10,000** 6-to-16-year-olds with a probable mental health disorder.
- According to latest data, in 2017, **just under 1 in 5 people aged 16 or over** in Croydon experienced a common mental health condition. If this proportion still holds true, it would mean that approximately **56,852 adults in Croydon could be currently experiencing a common mental health problem.**
- The figure on the right-hand side provides a summary of the most recent data on our mental health and wellbeing.

Summary data on mental health and wellbeing

Better 95% Similar Worse 95% Not applicable Quintiles: Best Worst Not applicable

Quintiles: Low High Not applicable Data quality concerns

Recent trends: Could not be calculated | No significant change | Increasing & getting worse | Increasing & getting better | Decreasing & getting worse | Decreasing & getting better | Increasing | Decreasing

Benchmark Value

Worst/Lowest | 25th Percentile | 75th Percentile | Best/Highest

Indicator	Period	Croydon			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Children & Young People									
93587 - Estimated number of children and young people with mental disorders – aged 5 to 17 ⚠	2017/18	–	-	8,031	-	-	-		- -
Common Mental Disorders									
Estimated prevalence of common mental disorders: % of population aged 16 & over	2017	–	55,088	18.4%*	19.3%*	16.9%*	24.4%		1.6%
Estimated prevalence of common mental disorders: % of population aged 65 & over	2017	–	5,540	10.8%*	11.3%*	10.2%*	14.6%		7.3%
Depression: QOF prevalence (18+ yrs)	2021/22	↑	-	9.1%	-	12.7%	6.1%		
Depression: QOF incidence (18+ yrs) - new diagnosis	2021/22	↑	4,287	1.3%	1.3%*	1.5%	0.8%		
90535 - Depression and anxiety among social care users: % of social care users ⚠	2018/19	–	-	49.9%	-	50.5%	63.6%		41.9%
Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+ ⚠	2016/17	–	608	11.5%*	-	13.7%	21.5%		8.8%
Severe Mental Illness									
Mental Health: QOF prevalence (all ages)	2021/22	↑	5,244	1.21%	1.11%*	0.95%	0.57%		
Long-term mental health problems (GP Patient Survey): % of respondents	2017/18	–	-	-	-	-	-		- -
Mental Health									
ESA claimants for mental and behavioural disorders: rate per 1,000 working age population	2018	→	4,470	18.5*	22.5*	27.3*	64.0		10.7
B07 - People in prison who have a mental illness or a significant mental illness	2018/19	–	-	-	-	7.35%	-	*Insufficient number of values for a spine chart*	

Source: Office of Health Improvement and Disparities

Building blocks of our health and wellbeing

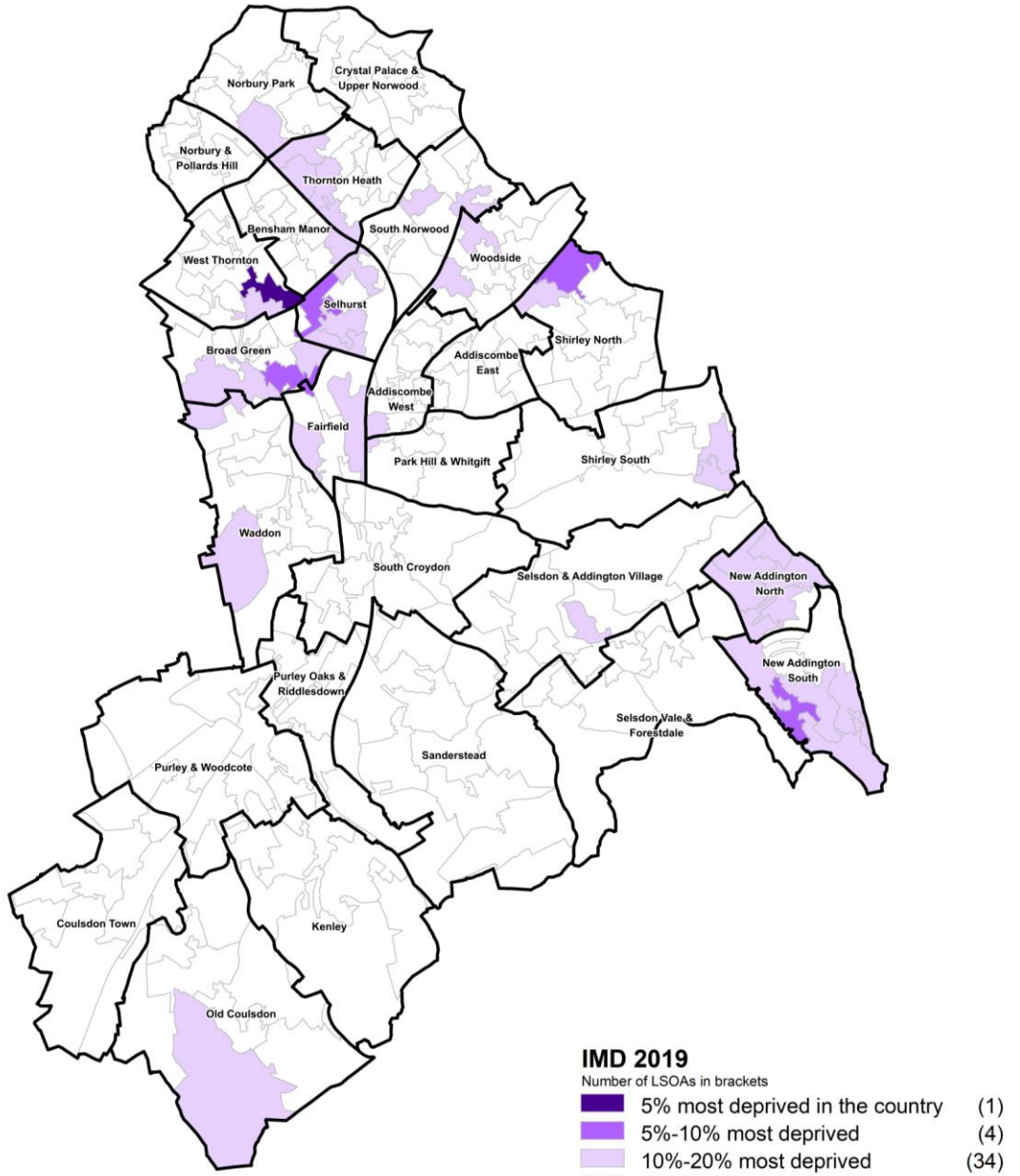
- Our health and wellbeing is shaped by almost every aspect of our lives—our homes, access to education, quality of jobs and working conditions, access to public transport and quality of our neighbourhoods, strength of our social connections or whether we experience poverty and discrimination. These building blocks are often referred to as 'wider determinants of health.'
- While access to health and social care impacts our health and wellbeing, these building blocks have a far greater impact. Existing research shows that healthcare itself contributes to between 15-25% of our health and wellbeing, while the wider determinants of health shape between 45-65% of our health and wellbeing (The King's Fund, 2013).
- This section presents insights on the following topics:
  - Deprivation and poverty
  - Housing
  - Economy and Employment
  - Education, skills and qualifications
  - Built and natural environment
  - Community Safety

Building blocks of our health and wellbeing: deprivation and poverty

Deprivation

- The **Index of Multiple Deprivation (IMD**) 2019 is the official measure of relative deprivation for small areas (or neighbourhoods) in England.
- The following seven domains are considered when calculating the overall IMD score: income, employment; education, skills and training; health deprivation and disability, crime, barriers to housing and services, and living environment.
- The latest IMD, IMD 2019, shows that **2.3%** of the small areas (also known as Lower Super Output Areas) in Croydon are among **the most 10% deprived areas in England**.
- The map on the right-hand side shows the areas in Croydon that are among the 20% most deprived areas in England. Darker shades correspond to higher deprivation.
- Detailed deprivation information, including information on individual deprivation domains, can be found at https://www.croydonobservatory.org/deprivation/#/view-report/8b97d75c317745b3a6016fc0788469d1/___iaFirstFeature/G3.

Indices of Deprivation (IMD) 2019 by Lower Super Output Areas:

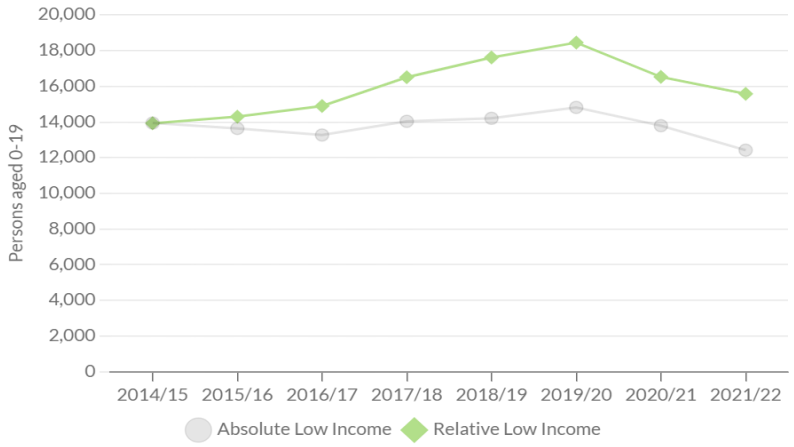


Building blocks of our health and wellbeing: deprivation and poverty

Poverty

- Income is one of the key building blocks of our health and wellbeing. In 2020/21, **13,766** children in Croydon lived in families with **absolute low-income**. During the same year, **16,649** children in Croydon lived in families with **relative low income.**
- Both absolute and relative income measures are calculated before housing costs. Housing costs are an essential expense and many individuals and families in poverty struggle to pay rent or afford adequate housing. Therefore, indicators accounting for housing costs are important for better understanding poverty.

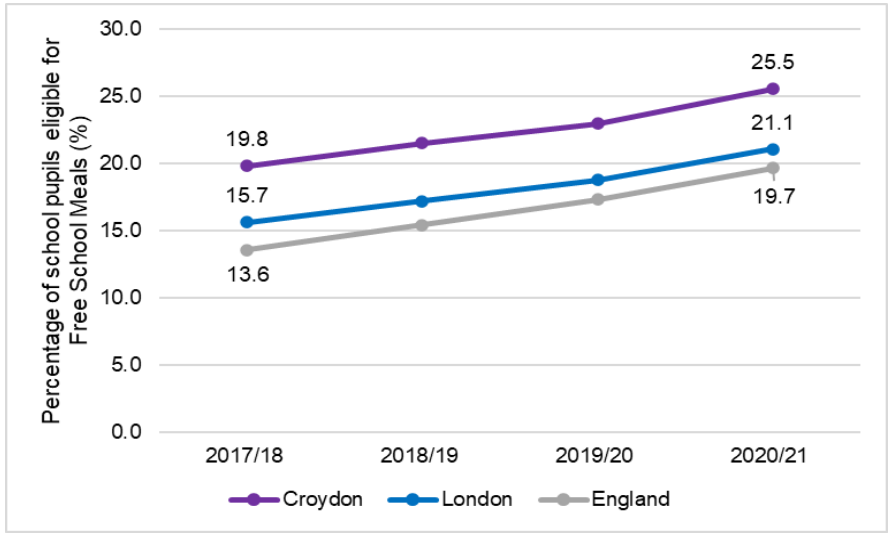
Number of children living in families with low income for Croydon



Source: Department of Work and Pensions

- In 2020/21, **child poverty rate** in Croydon, defined as the percentage aged 0-to-15 years who are living in households with below 60% median income after housing costs, was **32.1%**, down from 36.4% in the previous year. Croydon ranked **19th out of the 32** London Boroughs and the London average for the same period was 35.2%.
- The number and proportion of school pupils eligible **for Free School Meals** has been increasing in the recent years in Croydon. In 2020/21 Autumn term, **14,852 school pupils**, corresponding just above a quarter of Croydon's school pupils **(25.5%),** were eligible for Free School Meals. This was higher than the rate for London (21.1%) and England (19.7%).

Trends in percentage of school pupils eligible for Free School Meals in Croydon compared with those in London and England, 2017-2021



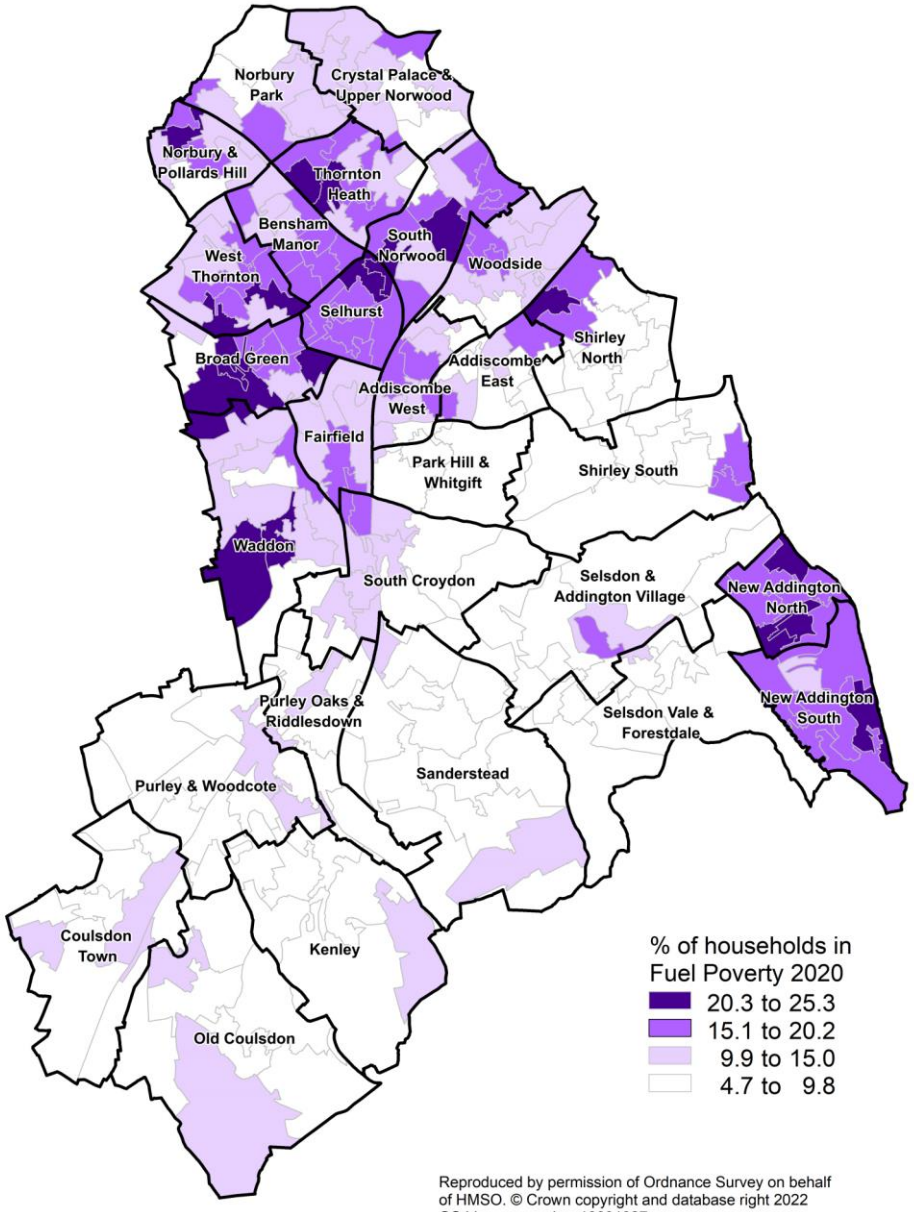
Source: Department for Education (2022)

Building blocks of our health and wellbeing: deprivation and poverty

Fuel poverty

- A household is said to be fuel poor if it needs to spend more than 10 per cent of its income on fuel to maintain an adequate standard of warmth. This is usually defined as 21 degrees for the main living room and 18 degrees for other occupied rooms. Fuel poverty statistics are estimated using data from the English Housing Survey (EHS).
- Fuel poverty is measured based on required energy bills rather than actual spending. This ensures that households that have low energy bills simply because they actively limit their use of energy at home, for example by not heating their home, are not overlooked.
- According to latest data (2021), **21,165 households (13.1%)** in Croydon were experiencing **fuel poverty.** The map on the right hand-side shows the percentage of households in fuel poverty across Croydon.
- Please see the next slide for a summary of general housing considerations in Croydon, including fuel poverty.

Percentage of households in Fuel Poverty 2020



Building blocks of our health and wellbeing: housing

- The quality of our homes influence our health and wellbeing. For example, we know that poor quality homes, such as cold, damp, and mouldy homes can lead to respiratory problems and other health issues, including adverse impacts on our mental health.
- The figure on the right-hand side summarises data available around housing affordability, fuel poverty, winter mortality index in Croydon.
- According to the 2011 Census, **3 in 5** of all Croydon 145,000 households were **owner occupied**, **1 in 5** were **private rented** and **juts under 1 in 5** were households living in social housing.
- Since 1997, housing affordability in Croydon, and elsewhere in London, has worsened overall. On average, people working in Croydon could expect to **pay almost eleven times their annual earnings** on purchasing a home within the borough in 2022. This is the third lowest ratio in London making Croydon **the third most affordable London borough to live and work in 2022**.

Housing summary

Better 95% Similar Worse 95% Not applicable Quintiles: Best Worst Not applicable

Recent trends: Could not be calculated; No significant change; Increasing & getting worse; Increasing & getting better; Decreasing & getting worse; Decreasing & getting better; Increasing; Decreasing

Benchmark Value: Worst | 25th Percentile | 75th Percentile | Best

Indicator	Period	Croydon			Region England	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Housing									
Affordability of home ownership	2021	–	415,000	11.4	13.7	9.1	24.8		4.4
Fuel poverty (low income, low energy efficiency methodology)	2021	–	21,165	13.1%	11.9%	13.1%	23.2%		2%
Winter mortality index	Aug 2020 - Jul 2021	–	430	55.6%	61.3%	36.2%	104.8%		6.5%
Emergency hospital admissions due to falls in people aged 65 and over	2021/22	–	1,030	1,908	2,187	2,100	3,272		1,394
Adults in contact with secondary mental health services who live in stable and appropriate accommodation	2020/21	–	-	32.0%	61.0%	58.0%	5.0%		86.0%
Adults with a learning disability who live in stable and appropriate accommodation	2021/22	↓	457	55.1%	77.5%	78.8%	34.4%		97.3%

Source: Office of Health Improvement and Disparities

- Over the last 10 years (2010/2011 -2019/2020), Croydon has built **4,626** affordable housing units. According to the latest data on affordable housing completions (2019/2020) , Croydon has the **fifth highest number** of these completions in London. More information on housing is found at https://www.croydonobservatory.org/housing/#/view-report/85fe651fd2af40e0bf133770aaa91687/___iaFirstFeature/G3.

Building blocks of our health and wellbeing: housing

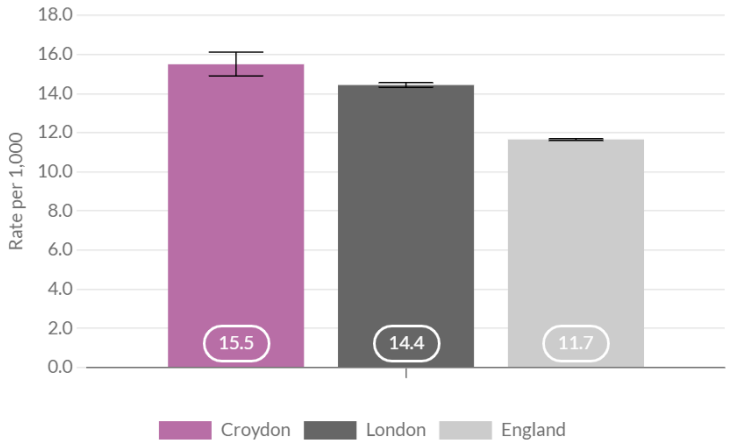
Homelessness

- Homelessness is associated with severe poverty and is a social determinant of health. It often results from a combination of events such as relationship breakdown, debt, adverse experiences in childhood and through ill health. The Homelessness Reduction Act (HRA) introduced new homelessness duties which meant significantly more households are being provided with a statutory service by local housing authorities than before the Act came into force.

- According to the Department of Levelling up Housing & Communities, at the end of Quarter 3 of 2022 (July to September 2022), **466** households were owed a prevention (assessed as threatened with homelessness) or relief duty (assessed as homeless).

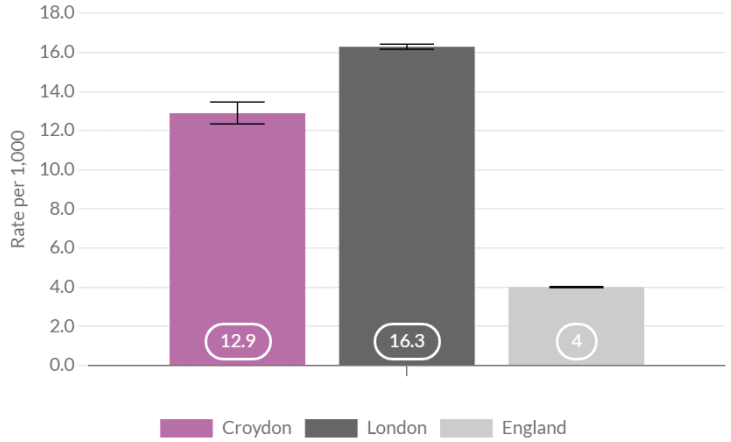
- During the same quarter, there were a total of **1,981** households in temporary accommodation in Croydon. Of these**,1,386** had dependent children and a total of **2,656** dependent children were affected.

Households owed a duty under the Homelessness Reduction Act (2021/22)



Source: Office for Health Improvement and Disparities

Households in temporary accommodation (2021/22)

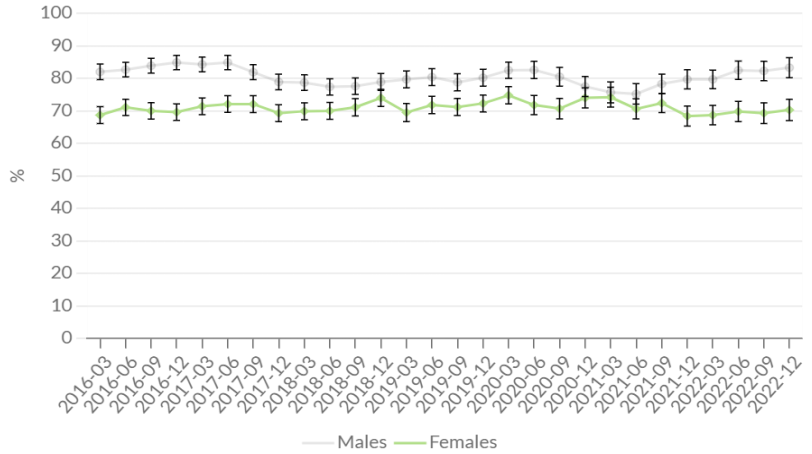


Source: Office for Health Improvement and Disparities

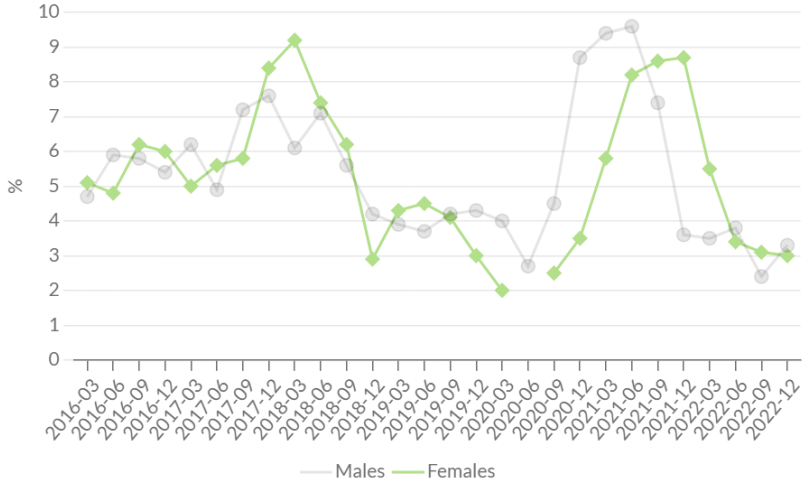
Building blocks of our health and wellbeing: economy and employment

- Croydon is a major economic centre in London and a primary retail, leisure and cultural destination for the South East. It is also a major contributor of labour and skills to the London economy and is recognised in the London Plan as an important strategic location for business activity and transport infrastructure.
- Many factors play a part in the success of a local economy, including natural resources, a workforce with skills, quality of infrastructure, strong linkages with wider economies and successful distribution of wealth.
- In December 2022, overall **employment rate** in Croydon was **76.0%**. During the same time, males and females had a **similar unemployment rate** at around **3%.**
- During the same time, **the most common reasons for economic inactivity** was **family (28.5%)** followed by **being a student (25.8%)** and **long-term sickness (25.5%).** Around **1 in 7** economically inactive people **wanted a job**.
- In August 2023, **14,630** people over the 16 years claimed out-of-work benefits.
- Universal Credit is a single payment for each household to help with living costs for those on a low income or out of work. In July 2023, a total of **20,171 working-aged men and 29,643 working-aged women** in Croydon claimed **universal credit**.
- For a detailed overview of economy and employment profile in Croydon, please see https://www.croydonobservatory.org/economy-and-employment/#/view-report/9e93e3faae4c449084e459fcd86e88d0/___iaFirstFeature/G3

Employment rate by gender (2016-2022)



Unemployment rate by gender (2016-2022)



Source: Annual Population Survey

Building blocks of our health and wellbeing: education, skills and qualifications

- Education plays a critical role in shaping our health and wellbeing. It significantly influences our access to opportunities, resources and socioeconomic conditions. It empowers us with the knowledge and skills needed to make informed health-related decisions.
- The impact education can have on our health and wellbeing extends beyond individuals, influencing the wellbeing of our families and communities, creating lasting effects across generations.
- According to Census 2021, just over **1 in 5 people** in Croydon (**79,478 people**) were school children or full-time students.
- Census 2021 also included data on the highest level of qualification. Accordingly, just under **1 in 6 people** aged 16 years and over, did not have a qualification. Please see the table below for the highest level of qualification achieved by our population who was 16 or older at the time of Census 2021. Comparisons are available with London and England.
- The next slide in this section covers a snapshot of latest data round school readiness, average attainment 8 scores and GCSE achievement in Croydon pupils. It also provides information on school absence and percentage of 16-year-olds who are Not in Education, Employment or Training (including not known).

Highest level of qualification, aged 16 or over, Census 2021.

Highest level of qualification	Croydon	(%)	London	(%)	England	(%)
No qualifications	49,877	16.1%	1,151,250	16.2%	8,317,789	18.1%
Level 1 and entry level qualifications	28,370	9.1%	545,269	7.7%	4,456,198	9.7%
Level 2 qualifications	38,241	12.3%	707,518	10.0%	6,126,130	13.3%
Apprenticeship	11,786	3.8%	227,622	3.2%	2,446,935	5.3%
Level 3 qualifications	45,535	14.7%	937,875	13.2%	7,784,977	16.9%
Level 4 qualifications and above	127,342	41.0%	3,316,829	46.7%	15,606,458	33.9%
Other qualifications	9,246	3.0%	217,622	3.1%	1,268,468	2.8%
Total: All usual residents aged 16 years and over	**310,397**	**100.0%**	**7,103,985**	**100.0%**	**46,006,955**	**100.0%**

Source: Office of National Statistics

Building blocks of our health and wellbeing: education, skills and qualifications

A summary of Education profile in Croydon.

Better 95% Similar Worse 95% Not applicable Quintiles: Best Worst Not applicable

Recent trends: Could not be calculated | No significant change | Increasing & getting worse | Increasing & getting better | Decreasing & getting worse | Decreasing & getting better | Increasing | Decreasing

Benchmark Value: Worst | 25th Percentile | 75th Percentile | Best

Indicator	Period	Croydon			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
School readiness: percentage of children achieving a good level of development at the end of Reception	2021/22	→	3,108	67.4%	67.8%	65.2%	53.1%		.4%
School Readiness: percentage of children with free school meal status achieving a good level of development at the end of Reception	2021/22	→	536	56.7%	56.2%	49.1%	35.2%		
School readiness: percentage of children achieving the expected level in the phonics screening check in Year 1	2021/22	→	3,461	74.9%	78.2%	75.5%	62.6%		83.4%
School readiness: percentage of children with free school meal status achieving the expected level in the phonics screening check in Year 1	2021/22	→	866	65.7%	68.7%	62.0%	44.1%		%
Average Attainment 8 score	2021/22	–	214,429	49.6	52.9*	48.7	39.2		
Average Attainment 8 score of children in care New data	2021/22	–	1,003	22.3	22.0	20.3	9.8		
GCSE achieved 5A*-C including English & Maths with free school meal status	2014/15	–	260	41.5%	45.8%	33.3%	20.5%		
Pupil absence	2021/22	↑	1,195,297	7.0%	6.7%	7.6%	9.2%		%
16 to 17 year olds not in education, employment or training (NEET) or whose activity is not known New data	2021/22	↓	471	4.9%	3.4%	4.7%	14.7%		1.4%

Source: Office of Health Improvement and Disparities

Building blocks of our health and wellbeing: built and natural environment

- The places and spaces we live, play, work and socialise play a pivotal role in shaping our physical and mental health and overall wellbeing.
- For example, access high quality green spaces could lower our stress levels, promote social activity and increase our daily physical activity, improving our physical and mental wellbeing. Similarly, safe, clean, healthy and well-connected neighbourhoods could cultivate a sense of belonging, feelings of security and safety, contributing to an overall sense of community and improved mental and emotional wellbeing. Conversely, environments characterised by pollution, noise and limited recreational areas could have adverse impacts on our physical and mental wellbeing. (GCPH 2013)
- The figure on the right-hand side summarises latest available data on Croydon's built natural environments including data on transport, neighbourhood design, and natural and sustainable environments.
- The most recent Environment Report for Croydon can be found at https://www.croydonobservatory.org/environment/#/view-report/04f70e9e81d54d578c2ccdc0c5456e23/___iaFirstFeature/G3.

Summary data on transport, neighbourhood design, and natural and sustainable environments.

Better 95% Similar Worse 95% Not applicable Quintiles: Best Worst Not applicable

Recent trends: Could not be calculated; No significant change; Increasing & getting worse; Increasing & getting better; Decreasing & getting worse; Decreasing & getting better; Increasing; Decreasing

Benchmark Value: Worst | 25th Percentile | 75th Percentile | Best

Indicator	Period	Croydon			Region England	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Transport									
Percentage of adults walking for travel at least three days per week	2019/20	–	-	19.1%	22.1%	15.1%	6.8%		
Percentage of adults cycling for travel at least three days per week	2019/20	–	-	1.3%	4.1%	2.3%	0.0%		
Killed and seriously injured (KSI) casualties on England's roads (historic data)	2016 - 18	–	-	-	-	-	-		-
Neighbourhood design									
The rate of complaints about noise	2020/21	→	10,689	27.5*	40.1*	12.0*	731.3		0.9
The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime	2016	–	42,150	11.1%	12.1%	5.5%	22.1%		0.9%
The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time	2016	–	55,260	14.6%	15.9%	8.5%	37.0%		1.3%
Number of premises licensed to sell alcohol per square kilometre	2021/22	–	-	*	13.7*	1.3*	91.9		0.3
Density of fast food outlets	2014	–	424	112.8	101.4	88.2	198.9		33.3
Access to Healthy Assets & Hazards Index	2022	–	216,766	55.8%	65.6%*	22.6%*	100%		0.0%
Natural and sustainable environments									
Access to woodland	2020	–	107,853	27.8%	11.9%	15.0%	0.0%		
Air pollution: fine particulate matter (new method - concentrations of total PM2.5)	2021	–	-	8.1	8.7	7.4	9.5		
Air pollution: fine particulate matter (historic indicator)	2020	–	-	8.7	8.9	6.9	10.0		
Utilisation of outdoor space for exercise or health reasons	Mar 2015 - Feb 2016	–	-	15.2%	18.0%	17.9%	5.1%		

Source: Office of Health Improvement and Disparities

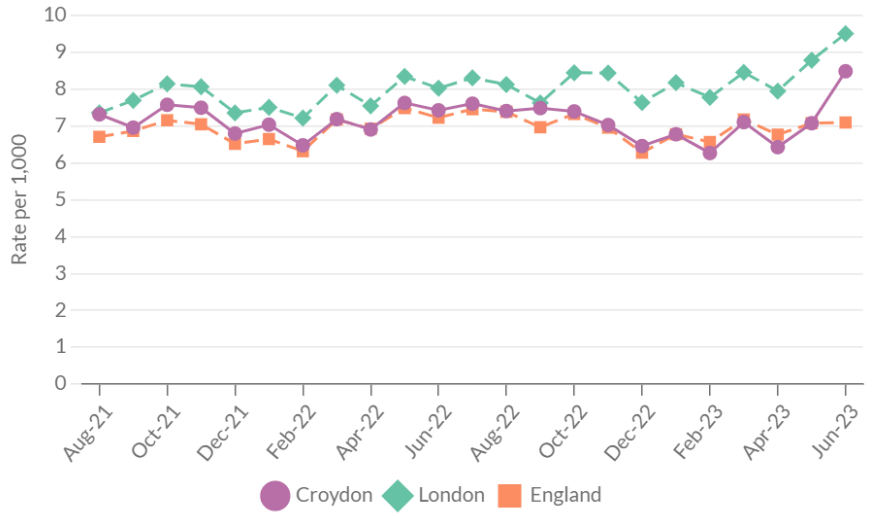
Building blocks of our health and wellbeing: community safety

Community safety

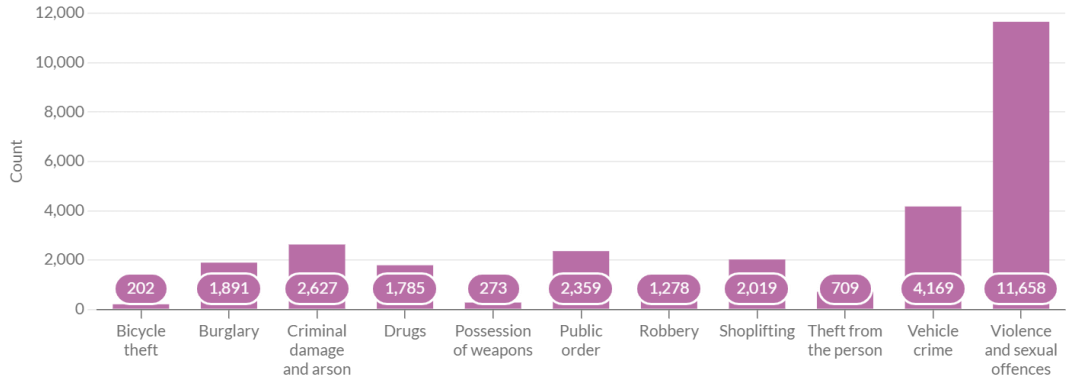
- Community safety plays a crucial role in shaping our health and wellbeing. Experiencing crime or fear of crime can adversely impact our mental and physical health. These impacts could be direct or indirect.
- For example, being a victim of crime could cause direct physical or mental harm, leading to poor health and wellbeing. Among some people, it could also lead to loss of confidence and isolation over time. Fear of crime impacts all of us and could erode our sense of freedom and personal safety, which could harm our health and wellbeing.

  Feeling safe and secure in our environment is an important enabler for behaviours, such as outdoor physical activity or social activities, that contribute positively to our overall health and wellbeing.
- This section summarises key data on community safety. Between July 2022 and June 2023, a total of **33,089** crimes were reported in Croydon. The figures on the right-hand side compares crime rates between Croydon, London and England and provides a breakdown of crimes by type.
- A detailed profile of Croydon's Crime & Community Safety can be found at https://www.croydonobservatory.org/crime-and-community-safety/#/view-report/48facb1714aa4261a67cbe7d59bfec28/___iaFirstFeature/G3.

All crime-monthly rates (July 2022-June 2023)



Crime by type (July 2022-June 2023)



Source: data.police.uk

Further information

The links below cover various data and intelligence report included in Croydon's JSNA. The wider JSNA can be accessed at https://www.croydonobservatory.org/jsna/.

Population overview
- Croydon Key Dataset
- Croydon Borough Profile
- Estimates of Croydon population
- Life expectancy in Croydon
- Estimates of personal wellbeing in Croydon
- OHID – Public Health Outcomes Framework- summary for Croydon

Population groups
- Children and Young People with Special Educational Needs and Disabilities
- Children Looked After Health Needs Assessment
- Children, young people and families in Croydon
- Children, young people and families in Croydon (summary)
- Health of Croydon's School-Aged Children
- OHID-Child and Maternal Health Reports for Croydon
- OHID- Fingertips Child Weight Profile
- OHID-Patterns and Trends in Child Obesity

Wider determinants
- Housing affordability in Croydon
- OHID-Fingertips Wider Determinants Profile
- Intelligent London- Education and Learning of young people in Croydon
- Metropolitan Police-Crime data
- Mayor's Office for Policing and Crime- Crime and Violence data

Healthy behaviours
- The Need for Specialist Drug and Alcohol Treatment in Croydon
- Improving Healthy Behaviours in Adults
- Sexual and Reproductive Health Needs Assessment
- Oral Health Needs Assessment
- OHID-Croydon Sexual Health Profile
- OHID-Fingertips Child Weight Profile
- OHID-Patterns and Trends in Child Obesity

Health conditions
- Croydon Self-Harm and Suicide Prevention Needs Assessment
- Croydon Pharmaceutical Needs Assessment
- Croydon Pharmaceutical Needs Assessment- Supplementary Statement
- Perinatal Mental Health Review
- Diagnosed Conditions in Croydon GPs
- Registered suicides in Croydon
- OHID-Fingertips Mental Health and Wellbeing Profile
- OHID-Public Mental Health Dashboard

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Equality Analysis Form

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1. Introduction

1.1 Purpose of Equality Analysis

The council has an important role in creating a fair society through the services we provide, the people we employ and the money we spend. Equality is integral to everything the council does. We are committed to making Croydon a stronger, fairer borough where no community or individual is held back.

Undertaking an Equality Analysis helps to determine whether a proposed change will have a positive, negative, or no impact on groups that share a protected characteristic. Conclusions drawn from Equality Analyses helps us to better understand the needs of all our communities, enable us to target services and budgets more effectively and also helps us to comply with the Equality Act 2010.

An equality analysis must be completed as early as possible during the planning stages of any proposed change to ensure information gained from the process is incorporated in any decisions made.

In practice, the term **'proposed change'** broadly covers the following:-

- Policies, strategies and plans;
- Projects and programmes;
- Commissioning (including re-commissioning and de-commissioning);
- Service review;
- Budget allocation/analysis;
- Staff restructures (including outsourcing);
- Business transformation programmes;
- Organisational change programmes;
- Processes (for example thresholds, eligibility, entitlements, and access criteria.

2. Proposed change

Directorate	**Assistant Chief Executive**
Title of proposed change	**Draft Joint Local Health and Wellbeing Strategy (2024-2029)**
Name of Officer carrying out Equality Analysis	**Shifa Sarica** **Jack Bedeman**

2.1 Purpose of proposed change (see 1.1 above for examples of proposed changes)

Briefly summarise the proposed change and why it is being considered/anticipated outcomes. What is meant to achieve and how is it seeking to achieve this? Please also state if it is an amendment to an existing arrangement or a new proposal.

What is the Joint Local Health and Wellbeing Strategy (JSHWS)?
The Joint Local Health and Wellbeing Strategy (JLHWS) sets out how the Health and Wellbeing Board will work together as a partnership, along with residents, to improve the health and wellbeing of our local communities. It is informed by local needs, as identified in the Joint Strategic Needs Assessment (JSNA), and views of partners and our local communities.

Why are we revising the strategy for 2024-2029?
Croydon's current JLHWS was published in 2019. Since then, the health and wellbeing and the health and care system in Croydon, like many other places, have seen important changes. One of these key changes in the health and care system is the implementation of the Health and Care Act 2022 and the subsequent creation of Integrated Care Systems. Integrated Care Systems are partnerships of organisations that bring together local authorities, NHS organisations and other system partners to plan and deliver joined-up health and care services within a geographical area. Croydon is now a part of the South West London Integrated Care System, which is made up of a total of six local authorities. The other local authorities in South West London Integrated Care System include Kingston, Merton, Richmond, Sutton and Wandsworth.

With the Health and Social Care Act 2022, Croydon's Health and Wellbeing Board continues to be responsible for the creation of Croydon's JLHWS. However, there is now a need to coordinate the JLHWS and the Integrated Care Strategy so that initiatives within Croydon and at the South West London system-level can have the greatest possible positive impact on our health and wellbeing. In addition to these recent reforms in the health and care system, the COVID-19 pandemic has shone a light on existing, and in some cases widening, health inequalities in Croydon. The cost-of-living crisis continues to pose significant challenges not only to the health and social care services but also to our health and wellbeing.

We are committed to keeping our strategy relevant, effective, and responsive to these changes. By reviewing and revising the JLHWS, we want to make sure it stays on track to address the evolving health needs and inequalities in Croydon.

PROPOSED CHANGES:
What is the vision for the draft JLHWS for 2024-2029?
The overall vision of the draft JLHWS is to achieve a Croydon where "everybody is enabled to lead a healthy, happy and fulfilling life, supported by safe, healthy and thriving communities and neighbourhoods'. We will work together and build on our strengths to actively tackle inequalities and improve our health and wellbeing.'

What are the priority areas of focus in the draft JLHWS?
1. Good mental health and wellbeing for all
2. Cost of living: supporting our residents to 'eat, sleep and have heat'
3. Healthy, safe and well-connected neighbourhoods and communities
4. Supporting our children, young people and families
5. Supporting our older population to live healthy, independent and fulfilling lives

What will underpin our actions? What are our guiding principles:
Our actions will be underpinned by the following guiding principles:
1- Tackling health inequalities: We will aim to reduce, and where possible prevent, health inequalities. In addition to taking action to improve the health and wellbeing of everybody in Croydon, we will take action to:

- Improve the health of the most disadvantaged groups, and
- Reduce the gap between the best and the worst off.

2- Prevention across the life course: We will take a prevention-first approach to prevent ill health from happening in the first place. We will embed principles of prevention across the life course, ensuring that our residents have the necessary tools and support, especially during key transition stages, to lead healthy and independent lives. We will aim to identify and tackle issues at the earlier possible opportunity to prevent them from getting worse.

3- Integrated partnership working: We will continue to improve integrated partnership working across health and social care at the local level, capitalising on the accomplishments of the One Croydon Alliance. We will actively engage in integrated partnership initiatives throughout South West London. We will endeavour to use our collective resources effectively, efficiently and sustainably, enabling our residents to find the right support, at the right time and at the right place.

4- Community focus and co-production: We are committed to taking a community-centric approach striving to shift more services to community settings, enabling community-led support to improve health and wellbeing. We will work in partnership with our residents and communities, recognising and building on their strengths.

5- Evidence-informed decisions and actions: We will base our strategic decisions and actions, including our commissioning, on the best available evidence. This principle ensures that our actions are effective, efficient, and aligned with the evolving needs of our communities. We will establish clear oversight and monitoring processes to assess the impact of our strategies and actions.

3. Impact of the proposed change

Important Note: It is necessary to determine how each of the protected groups could be impacted by the proposed change. Who benefits and how (and who, therefore doesn't and why?) Summarise any positive impacts or benefits, any negative impacts and any neutral impacts and the evidence you have taken into account to reach this conclusion. Be aware that there may be positive, negative and neutral impacts within each characteristic.
Where an impact is unknown, state so. If there is insufficient information or evidence to reach a decision you will need to gather appropriate quantitative and qualitative information from a range of sources e.g. Croydon Observatory a useful source of information such as Borough Strategies and Plans, Borough and Ward Profiles, Joint Strategic Health Needs Assessments http://www.croydonobservatory.org/ Other sources include performance monitoring reports, complaints, survey data, audit reports, inspection reports, national research and feedback gained through engagement with service users, voluntary and community organisations and contractors.

3.1 Deciding whether the potential impact is positive or negative

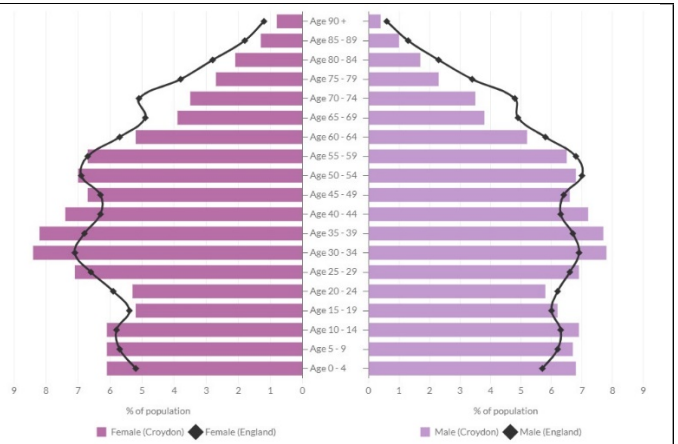
Table 1 – Positive/Negative impact

For each protected characteristic group show whether the impact of the proposed change on service users and/or staff is positive or negative by briefly outlining the nature of the impact in the appropriate column. . If it is decided that analysis is not relevant to some groups, this should be recorded and explained. In all circumstances you should list the source of the evidence used to make this judgement where possible.

Protected characteristic group(s)	Positive impact	Negative impact	Source of evidence

Age	One of the guiding principles in the draft strategy is "**Prevention across the life course**: We will take a prevention-first approach to prevent ill health from happening in the first place. We will embed principles of prevention across the life course, ensuring that our residents have the necessary tools and support, especially during key transition stages, to lead healthy and independent lives. We will aim to identify and tackle issues at the earlier possible opportunity to prevent them from getting worse." Focusing on the entire life course is anticipated to benefit people of all ages. Actions towards priority 4 ("Supporting our children, young people and families") will specifically benefit **younger ages,** while actions towards Priority 5 ("Supporting our older population to live healthy, independent and fulfilling lives") will benefit **older age groups.** While there isn't a specific priority focusing on working-age adults, we expect actions in all priority areas, specifically the following to positively impact this group: • Priority 1: Good mental health and wellbeing for all • Priority 2: Supporting residents to 'sleep, eat and have heat' • Priority 3: Healthy, safe and well-connected neighbourhoods and communities • Priority 4: Supporting our children, young people **and families** so that our children and young people can have the best start in life and the opportunities they need to reach their potential.	At present, there is no evidence suggesting that the implementation of this draft strategy will negatively impact individuals within this protected group.	**Census 2021** • With a population of 390,719, Croydon is the largest borough in London by population. The figure below shows the population of Croydon, by broad age groups: 

<table>
<tr>
<td>Disability</td>
<td>Actions across all priority areas are anticipated to have positive impacts for people with disability. Some anticipated positive impacts include the following:
Improved mental health and wellbeing for all, including a specific focus on people with learning disabilities
Improved general health and wellbeing outcomes in particularly low-income individuals through the specific focus on cost-of-living support
Improved physical, social, mental and emotional health through work on healthy, safe and well-connected neighbourhoods and communities
Improved support for children, young people and families, including those with Special Educational Needs and Disabilities.
Improved health and wellbeing outcomes for older people so they can live healthy, independent and fulfilling lives. Actions in this area will support our older residents to stay physically and mentally well and maintain independence as long as possible.</td>
<td>At present, there is no evidence suggesting that the implementation of this draft strategy will negatively impact individuals within this protected group.</td>
<td>Census 2021
According to the 2021 Census, 54,825 individuals (15.8% of the population) in Croydon were disabled under the Equality Act. Of these, 31,136 had their day-to-day activities limited a little, and 23,716 had their day-to-day activities limited a lot.
While 72.4% of the households had no people disabled under the Equality Act in the household, 22.1% household had one person disabled under the Equality Act and 5.5% of the households had two or more people disabled in the household under the Equality Act.
<table><tr><th>Disability status by household</th><th>Number of households</th></tr><tr><td>No people disabled under the Equality Act in household</td><td>110,761</td></tr><tr><td>1 person disabled under the Equality Act in household</td><td>33,725</td></tr><tr><td>2 or more people disabled under the Equality Act in household</td><td>8,459</td></tr></table></td>
</tr>
<tr>
<td>Sex</td>
<td>Actions across all priority areas are anticipated to have positive impacts for people of all sexes. For example, we anticipate positive impacts through:
Improved mental health outcomes in men and women through actions towards draft priority 1. Good mental health and wellbeing for all and draft priority 4. Supporting our children, young people and families
Prevention of domestic violence and violence against women, through actions towards draft priority 3:</td>
<td>At present, there is no evidence suggesting that the implementation of this draft strategy will negatively impact individuals within this protected group.</td>
<td>Census 2021
Croydon’s population is 51.9% female and 48.1% male (2021).
For age groups younger than20, there is a slightly higher proportion of males than females. However, there is slightly a higher proportion of females than males in working-age and older age groups. A population pyramid showing percentage of population by 5-year age groups is provided below.</td>
</tr>
</table>

<table>
<tr>
<td></td>
<td>healthy, safe and well-connected neighbourhoods and communities</td>
<td></td>
<td> 
</td>
</tr>
<tr>
<td>Gender Reassignment</td>
<td>Actions across all priority areas are anticipated to have positive impacts for all people, regardless of their gender.</td>
<td>At present, there is no evidence suggesting that the implementation of this draft strategy will negatively impact individuals within this protected group.</td>
<td>Census 2021:
• In 2021, about 2,765 people in Croydon identified as a gender different from their sex registered at birth. A detailed breakdown is provided below.

<table>
<tr><th>Gender identity</th><th>Percentage (%)</th><th>Number of people</th></tr>
<tr><td>Gender identity the same as sex registered at birth</td><td>91.60</td><td>284,319</td></tr>
<tr><td>Gender identity different from sex registered at birth but no specific identity given</td><td>0.46</td><td>1,420</td></tr>
<tr><td>Trans woman</td><td>0.17</td><td>515</td></tr>
<tr><td>Trans man</td><td>0.18</td><td>558</td></tr>
<tr><td>Non-binary</td><td>0.05</td><td>165</td></tr>
<tr><td>All other gender identities</td><td>0.03</td><td>107</td></tr>
<tr><td>Not answered</td><td>7.51</td><td>23,314</td></tr>
</table></td>
</tr>
<tr>
<td>Marriage or Civil Partnership</td>
<td>Actions across all priority areas are anticipated to have positive impacts for all people, regardless of their marriage or civil partnership status.</td>
<td>At present, there is no evidence suggesting that the implementation of this draft strategy will negatively impact individuals within this protected group.</td>
<td>Census 2021:
• In 2021, Around 43% of Croydon residents were never married and never registered in a civil partnership, while around 42% were married or registered in a civil partnership. A detailed breakdown of legal partnership status is provided in the table below.</td>
</tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td></td>
<td>
<table>
<tr><th>Legal partnership status</th><th>Number of people</th><th>Percentage (%)</th></tr>
<tr><td>Never married and never registered a civil partnership</td><td>133,181</td><td>42.9</td></tr>
<tr><td>Married or in a registered civil partnership</td><td>129,228</td><td>41.6</td></tr>
<tr><td>Separated, but still legally married or still legally in a civil partnership</td><td>8,242</td><td>2.7</td></tr>
<tr><td>Divorced or civil partnership dissolved</td><td>25,175</td><td>8.1</td></tr>
<tr><td>Widowed or surviving civil partnership partner</td><td>14,572</td><td>4.7</td></tr>
</table>
</td>
</tr>
<tr>
<td>Religion or belief</td>
<td>Actions across all priority areas are anticipated to have positive impacts for all people, regardless of their religion or belief.</td>
<td>At present, there is no evidence suggesting that the implementation of this draft strategy will negatively impact individuals within this protected group.</td>
<td>
Census 2021:
Around 49% of Croydon residents stated that they were Christian and 26% stated they had no religion. 7% did not state their religion.
<table>
<tr><th>Religion</th><th>Number of people</th><th>Percentage (%)</th></tr>
<tr><td>Christian</td><td>190,880</td><td>48.9</td></tr>
<tr><td>Buddhist</td><td>2,371</td><td>0.6</td></tr>
<tr><td>Hindu</td><td>23,145</td><td>5.9</td></tr>
<tr><td>Jewish</td><td>609</td><td>0.2</td></tr>
<tr><td>Muslim</td><td>40,717</td><td>10.4</td></tr>
<tr><td>Sikh</td><td>1,654</td><td>0.4</td></tr>
<tr><td>Other religion</td><td>3,189</td><td>0.8</td></tr>
</table>
</td>
</tr>
<tr>
<td>Race</td>
<td>The strategy puts a large emphasis on tackling health inequalities through improving the health of the most disadvantaged groups and reducing the gap between the best and the worst off. It also commits to taking a community centric approach, enabling community-led support to improve health and wellbeing. Guided by these principles, actions across all priority areas are anticipated to have positive impacts for all people.

We anticipate positive impacts on our Global Majority groups through:</td>
<td>At present, there is no evidence suggesting that the implementation of this draft strategy will negatively impact individuals within this protected group.</td>
<td>
Census 2021:
Around 52% of Croydon’s population come from Global Majority groups.
<table>
<tr><th>Ethnicity</th><th>Number of people</th><th>Percen (%)</th></tr>
<tr><td>Asian, Asian British or Asian Welsh</td><td>68,487</td><td></td></tr>
<tr><td>Black, Black British, Black Welsh, Caribbean or African</td><td>88,441</td><td></td></tr>
<tr><td>Mixed or Multiple ethnic groups</td><td>29,745</td><td></td></tr>
<tr><td>White</td><td>188,985</td><td></td></tr>
<tr><td>Other ethnic group</td><td>15,066</td><td></td></tr>
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Promoting culturally competent health and care services
Establishing the use of an anti-racism framework
Targeted activities to improve the health and wellbeing outcomes of our Global Majority population.

</td>
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<td>

Around 5 in 6 (84%) of people speak English as their main language. After English, South Asian (4.8%) languages, Other European (EU) language (4.7%), Portuguese (1.3%), Spanish (1.0%) and East Asian (0.8%) are the most common main languages.

<table>
<tr><th>Household language</th><th>Count</th><th>Percentage (%)</th></tr>
<tr><td>All adults in household have English in England as a main language</td><td>122,932</td><td>80.4</td></tr>
<tr><td>At least one but not all adults in household have English as a main language</td><td>12,189</td><td>8.0</td></tr>
<tr><td>No adults in household, but at least one person aged 3 to 15 years, has English as a main language</td><td>4,453</td><td>2.9</td></tr>
<tr><td>No people in household have English in England as a main language</td><td>13,372</td><td>8.7</td></tr>
</table>
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<tr>
<td>Sexual Orientation</td>
<td>The overall vision of the draft JLHWS is to achieve a Croydon where “everybody is enabled to lead a healthy, happy and fulfilling life, supported by safe, healthy and thriving communities and neighbourhoods. We will work together and build on our strengths to actively tackle inequalities and improve our health and wellbeing.’

Actions across all priority areas are anticipated to have positive impacts for all people, regardless of their sexual orientation. We anticipate specific mental health benefits to our LGBTQ+ population through targeted actions focusing on draft Priority 1. Good mental health and wellbeing for all.</td>
<td>At present, there is no evidence suggesting that the implementation of this draft strategy will negatively impact individuals within this protected group.</td>
<td>
Census 2021:

According to the Census 2021, in March 2021, 3.1% of Croydon’s population, around 9,520 individuals, identified as lesbian, gay, bisexual and other non-straight identities including, pansexual, asexual, queer and other. A detailed breakdown of sexual orientation is provided below.

<table>
<tr><th>Sexual orientation</th><th>Number of people</th><th>Percentage (%)</th></tr>
<tr><td>Straight or Heterosexual</td><td>272,523</td><td>87.80</td></tr>
<tr><td>Gay or Lesbian</td><td>4,696</td><td>1.51</td></tr>
<tr><td>Bisexual</td><td>3,661</td><td>1.18</td></tr>
<tr><td>Pansexual</td><td>855</td><td>0.28</td></tr>
<tr><td>Asexual</td><td>123</td><td>0.04</td></tr>
<tr><td>Queer</td><td>97</td><td>0.03</td></tr>
<tr><td>All other sexual orientations</td><td>98</td><td>0.03</td></tr>
<tr><td>Not answered</td><td>28,344</td><td>9.13</td></tr>
</table>
</td>
</tr>
</table>

			LGBTQI+ Youth and Mental Health: A Systematic Review of Qualitative Research • One in three lesbian, gay, bisexual, transgender, and queer (LGBTQ+) young people within the UK experience mental health difficulties, compared to one in eight young people within the general population

Pregnancy or Maternity	The overall vision of the draft JLHWS is to achieve a Croydon where "everybody is enabled to lead a healthy, happy and fulfilling life, supported by safe, healthy and thriving communities and neighbourhoods. We will work together and build on our strengths to actively tackle inequalities and improve our health and wellbeing.'
	
	Actions across all priority areas are anticipated to have positive impacts for all people. Specifically, actions towards draft priority 4. Supporting our children, young people and families are anticipated to have positive impacts on pregnant individuals. Some positive outcomes include:
	• Providing targeted interventions to high risk pregnant individuals, such as interventions aimed at:
	  • Helping individuals to stop smoking during pregnancy
	  • Helping pregnant individuals to access healthy food and supplements during pregnancy
	  • Improving New Birth Visit rates
	  • Improving parental mental health
		At present, there is no evidence suggesting that the implementation of this draft strategy will negatively impact individuals within this protected group.	**Children, young people and families in Croydon rapid needs assessment**
			• The total number of births born to mothers resident in Croydon has been decreasing since 2016. In 2021, there were 5,001 live births, down from over 5,252 in 2020.
			• 44.7% of deliveries were to mothers from Black, Asian and Minority ethnic groups.
			• Under 16s conception rate in Croydon has been relatively stable in the recent years. In 2020, this rate was 1.7 per 1,000 which was similar to that in the wider London region and in England.
			• Under 18s conception rate in Croydon has been decreasing in the recent years. In 2020, the rate was 11.3 per 1,000, a rate similar to that in the wider London region and that in England.
			• The rate of births to teenage mothers have been relatively stable in Croydon. In 2021/22, 0.6% of all live births were to teenage mothers.
			• The percentage of mothers smoking at the time of delivery has been decreasing in Croydon. In 2021/22, there were a total of 210 (5.5%) mothers reported to have been smoking at the time of delivery. This rate is higher than that in London (4.5%) but lower than that in England (9.1%).
			• Latest data (2018/19) showed that Croydon rates of folic acid supplements before pregnancy (25.3%) and early access to maternity care (38.4%) were lower than that in the London region (28.5% and 47.8%, respectively).
			• During the same period (2018/19), 23.2% of women were reported to have obesity in early

			pregnancy. This was worse than the overall London value (17.8%) but similar to that in England (22.1%). • Trends in low and very low birth weight of all babies, and low birth weight of term babies have been relatively steady in recent years. In 2020, 8.7% of all babies at low birth weight and 1.3% had very low birth rate. In the same year, 3.7% of all term babies had low birthweight. These figures have been generally similar to those in the wider London region except for low birth weight of all babies which is worse than that in London (8.7%vs 7.5%). • During 2019-21, 85 stillbirths were reported in Croydon, equating to a rate of 5.4 per 1,000 births. This rate was higher than that in the London region (4.3 per 1,000) and England (3.9 per 1,000). • In 2021/22, Baby First Feed was breast milk for 84.8% of babies in Croydon. This is lower than the London region average (87.7%), but higher than England average (71.7%). • 85.8% of New Birth Visits were completed within 14 days by a health visitor. This was lower than that in the London region (87.8%) but higher than that in England (82.6%). • The mental health of parents can have an impact on the current and future health and wellbeing of their children and shape their social and educational outcomes. National surveys and international meta-analyses suggest that up to 20% of women and 10% of men are estimated to have a mental illness during pregnancy and the year after birth. This would mean that up to 1,000 pregnant mothers and 500 fathers would have been expected to be affected by mental illness sometime during the perinatal period in Croydon in 2021. • ONS Census 2021 identified a total of 152,947 households in Croydon, of which just over a third (51,709, 33.8%) were household types with

			dependent children. Of the households with dependent children, 29% were lone parent, single family households

Important note: You must act to eliminate any potential negative impact which, if it occurred would breach the Equality Act 2010. In some situations this could mean abandoning your proposed change as you may not be able to take action to mitigate all negative impacts.

When you act to reduce any negative impact or maximise any positive impact, you must ensure that this does not create a negative impact on service users and/or staff belonging to groups that share protected characteristics. **Please use table 4 to record actions that will be taken to remove or minimise any potential negative impact**

3.2 Additional information needed to determine impact of proposed change

Table 2 – Additional information needed to determine impact of proposed change

If you need to undertake further research and data gathering to help determine the likely impact of the proposed change, outline the information needed in this table. Please use the table below to describe any consultation with stakeholders and summarise how it has influenced the proposed change. Please attach evidence or provide link to appropriate data or reports:

Additional information needed and or Consultation Findings	Information source	Date for completion

For guidance and support with consultation and engagement visit https://intranet.croydon.gov.uk/working-croydon/communications/consultation-and-engagement/starting-engagement-or-consultation

3.3 Impact scores

Example
If we are going to reduce parking provision in a particular location, officers will need to assess the equality impact as follows;

1. Determine the Likelihood of impact. You can do this by using the key in table 5 as a guide, for the purpose of this example, the likelihood of impact score is 2 (likely to impact)
2. Determine the Severity of impact. You can do this by using the key in table 5 as a guide, for the purpose of this example, the Severity of impact score is also 2 (likely to impact)
3. Calculate the equality impact score using table 4 below and the formula **Likelihood x Severity** and record it in table 5, for the purpose of this example - **Likelihood** (2) x **Severity** (2**) = 4**

Table 4 – Equality Impact Score

Severity of Impact				
	3	3	6	9
	2	2	4	6
	1	1	2	3
		1	2	3
	Likelihood of Impact			

Key

Risk Index	Risk Magnitude
6 – 9	High
3 – 5	Medium
1 – 3	Low

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Table 3 – Impact scores

Column 1 **PROTECTED GROUP**	Column 2 **LIKELIHOOD OF IMPACT SCORE** Use the key below to **score** the **likelihood** of the proposed change impacting each of the protected groups, by inserting either 1, 2, or 3 against each protected group. **1 = Unlikely to impact** **2 = Likely to impact** **3 = Certain to impact**	Column 3 **SEVERITY OF IMPACT SCORE** Use the key below to **score** the **severity** of impact of the proposed change on each of the protected groups, by inserting either 1, 2, or 3 against each protected group. **1 = Unlikely to impact** **2 = Likely to impact** **3 = Certain to impact**	Column 4 **EQUALITY IMPACT SCORE** Calculate the **equality impact score** for each protected group by multiplying scores in column 2 by scores in column 3. Enter the results below against each protected group. **Equality impact score = likelihood of impact score x severity of impact score.**
Age	**3**	**1**	**3**
Disability	**3**	**1**	**3**
Sex	**3**	**1**	**3**
Gender reassignment	**3**	**1**	**3**
Marriage / Civil Partnership	**3**	**1**	**3**
Race	**3**	**1**	**3**
Religion or belief	**3**	**1**	**3**
Sexual Orientation	**3**	**1**	**3**
Pregnancy or Maternity	**3**	**1**	**3**

Equality Analysis

4. Statutory duties

4.1 Public Sector Duties

Tick the relevant box(es) to indicate whether the proposed change will adversely impact the Council's ability to meet any of the Public Sector Duties in the Equality Act 2010 set out below.

Advancing equality of opportunity between people who belong to protected groups ☐

Eliminating unlawful discrimination, harassment and victimisation ☐

Fostering good relations between people who belong to protected characteristic groups ☐

Important note: If the proposed change adversely impacts the Council's ability to meet any of the Public Sector Duties set out above, mitigating actions must be outlined in the Action Plan in section 5 below.

5. Action Plan to mitigate negative impacts of proposed change

Important note: Describe what alternatives have been considered and/or what actions will be taken to remove or minimise any potential negative impact identified in Table 1. Attach evidence or provide link to appropriate data, reports, etc:

Table 4 – Action Plan to mitigate negative impacts

Complete this table to show any negative impacts identified for service users and/or staff from protected groups, and planned actions mitigate them.

Protected characteristic	Negative impact	Mitigating action(s)	Action owner	Date for completion
Disability				
Race				
Sex (gender)				
Gender reassignment		**N/A**		
Sexual orientation				
Age				
Religion or belief				
Pregnancy or maternity				

Equality Analysis

Marriage/civil partnership	

6. Decision on the proposed change

Based on the information outlined in this Equality Analysis enter **X** in column 3 (**Conclusion**) alongside the relevant statement to show your conclusion.

Decision	Definition	Conclusion - Mark 'X' below
No major change	Our analysis demonstrates that the policy is robust. The evidence shows no potential for discrimination and we have taken all opportunities to advance equality and foster good relations, subject to continuing monitoring and review. **If you reach this conclusion, state your reasons and briefly outline the evidence used to support your decision**.	**x**
Adjust the proposed change	We will take steps to lessen the impact of the proposed change should it adversely impact the Council's ability to meet any of the Public Sector Duties set out under section 4 above, remove barriers or better promote equality. We are going to take action to ensure these opportunities are realised. **If you reach this conclusion, you must outline the actions you will take in Action Plan in section 5 of the Equality Analysis form**	
Continue the proposed change	We will adopt or continue with the change, despite potential for adverse impact or opportunities to lessen the impact of discrimination, harassment or victimisation and better advance equality and foster good relations between groups through the change. However, we are not planning to implement them as we are satisfied that our project will not lead to unlawful discrimination and there are justifiable reasons to continue as planned. **If you reach this conclusion, you should clearly set out the justifications for doing this and it must be in line with the duty to have due regard and how you reached this decision.**	
Stop or amend the proposed change	Our change would have adverse effects on one or more protected groups that are not justified and cannot be mitigated. Our proposed change must be stopped or amended.	

Will this decision be considered at a scheduled meeting? e.g. Contracts and Commissioning Board (CCB) / Cabinet	Meeting title: Health and Wellbeing Board Date: 25 January 2024

Equality Analysis

7. Sign-Off

Officers that must approve this decision		
Equalities Lead	Name: Position:	Date:
Director	Name: Position:	Date:

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